

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 0 2 8

REG. NO.

FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |  |   |  |  |
|---|--|---|--|---|--|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>ANNA MARY ANDERSON  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 16, 1986               |   |  | 2b. HOUR<br>M  |   |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 29, 1927   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>58 YRS  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Glen Burnie  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>302 Greenway S. E. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                              |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>Anne Arundel  |   | 13c. CITY OR TOWN<br>Glen Burnie   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Joseph Brendel   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna C. Hinkleman     |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No N/A |   |  |  |
| 16b. SOCIAL SECURITY NO.<br>215-24-6598   |  |   | 17. INFORMANT (Son)<br>Mr. William C. Anderson                         |   |  | ADDRESS<br>Same as #13   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Sudden death probably Myocardial Infarct</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis, Arteriovenous Conduction sys</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>2yr I Probable Malignancy with retinopathy, neuropathy</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>2yr I Probable Malignancy with retinopathy, neuropathy</u> |  |   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION<br>1   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/15</u> 19 <u>81</u> to <u>11/16</u> 19 <u>86</u> , that (I) (we) lost<br>saw the deceased alive on <u>11/06</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><u>Michael F. Garahy</u>  |  |   | DEGREE<br>M.D.   |   |  | 22c. DATE SIGNED<br>11/17/86   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Michael F. Garahy M.D.   |  |   | 22e. ADDRESS<br>8651 Fort Smallwood Road Pasadena, Md.                 |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 23b. DATE<br>November 20, 1986   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Park                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Elkridge Howard Md.                               |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>G. H. Haskin</u>   |  |   | 1 Second Ave. S. W.<br>Glen Burnie, Md.                                |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 18 1986   |   | 25b. REGISTRAR'S SIGNATURE<br><u>John Anderson-Kennedy</u>   |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2430 100

COLL. 1866

CHIEFMAN



00-23081

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased be interred within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  | 8 6 3 0 2 8 8  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |
| FIRST MIDDLE LAST<br>CARSON Leonard ANDERSON  |  |  |  |  | MONTH DAY YEAR<br>NOVEMBER 3, 1986   |  |  |  |  |
| 3. SEX  |  |  |  |  | 2b. HOUR   |  |  |  |  |
| Male  |  |  |  |  | 1320 P M   |  |  |  |  |
| 4. RACE   |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  |
| White   |  |  |  |  | MONTH DAY YEAR<br>August 10, 1910  |  |  |  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)   |  |  |  |  | 7. IF UNDER 1 YEAR   |  |  |  |  |
| 76 YRS  |  |  |  |  | MONTHS DAYS HOURS MIN.   |  |  |  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |  |
| W. Virginia   |  |  |  |  | Anne Arundel MD.   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |
| Glen Burnie   |  |  |  |  | North Arundel Hospital   |  |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |
| Finishing   |  |  |  |  | Nevar-Mar  |  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  | 13b. CITY OR TOWN  |  |  |  |  |
| 13a. STATE  |  |  |  |  | 13b. COUNTY  |  |  |  |  |
| Maryland  |  |  |  |  | A A Co. Glen Burnie  |  |  |  |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)   |  |  |  |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)   |  |  |  |  |
| (UNKNOWN)   |  |  |  |  | Martha (UNKNOWN)   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  |
| No  |  |  |  |  | 224.28.1270  |  |  |  |  |
| 17. INFORMANT (Son)   |  |  |  |  | ADDRESS  |  |  |  |  |
| Mr. Edward C. Anderson  |  |  |  |  | 111 Northdale Road Glen Burnie, Md. 21061  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.   |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u>   |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sick Sinus Syndrome, Hypertension</u>   |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Sick Sinus Syndrome, Hypertension</u>   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |
| 20a. AUTOPSY?   |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |  |  |  |
| YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  | 21b. TIME OF INJURY  |  |  |  |  |
|   |  |  |  |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  |  |
| 21d. INJURY OCCURRED  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  |  |  |
| AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  |  | 21f. LOCATION  |  |  |  |  |
|   |  |  |  |  | STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>7-Sept</u> 19 <u>84</u> to <u>3-Nov</u> 19 <u>86</u> , that (1) <u>my</u> lost the deceased alive on <u>20-Oct</u> 19 <u>86</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (1) <u>my</u> <u>did not</u> view the body after death. |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  |  | 22c. DATE SIGNED   |  |  |  |  |
| <u>Richard F. Fisher</u>  |  |  |  |  | 3-Nov-86   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  | 22e. ADDRESS   |  |  |  |  |
| Dr. Richard F. Fisher   |  |  |  |  | 4710 Pennington Ave. Baltimore, Maryland 21226   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  |  | 23b. DATE  |  |  |  |  |
| Cremation   |  |  |  |  | Nov 6, 1986  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY  |  |  |  |  | 23d. LOCATION  |  |  |  |  |
| Security Process, Inc.  |  |  |  |  | Catonsville Balto. Md.   |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  | 25a. DATE REC'D BY REGISTRAR   |  |  |  |  |
| <u>HB V...</u>  |  |  |  |  | NOV - 5 1986   |  |  |  |  |
| Singleton Funeral Home, Glen Burnie, Md.  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |
|   |  |  |  |  | <u>Julia Benson-Randall</u>  |  |  |  |  |

BP





025265 NOV 25 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 and place them in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |   | 8 6 3 0 2 8 9  |                    |   |  |
|--|--|--|--|--|--|---|--|--|---|--|--------------------|---|--|
| FOR: 1 - STATE REGISTRAR   |  |  |  |  |  |   |  |  |   | REG. NO.   |                    |   |  |
| 3. SEX<br>FEMALE   |  |  | 4. RACE<br>BLACK   |  |  | 5. DATE OF BIRTH<br>MONTH 7 DAY 27 YEAR 10  |  |  | 2a. DATE OF DEATH<br>MONTH 11 DAY 21 YEAR 86  |  | 2b. HOUR<br>1430 M |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ANNE ARUNDEL MD.  |  |                    |   |  |
| 10. CITY OR TOWN OF DEATH<br>ANNE ARUNDEL  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ARUNDEL GENERAL Hosp. |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>UNEMP.  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                    |   |  |
| 13a. STATE<br>MD   |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN<br>BALTO.   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |                    | 13e. STREET ADDRESS / ZIP CODE<br>507 N. BETHEL ST. 21213 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>EMANUEL Smith  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>CUSSIE MACK   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |  | 16b. SOCIAL SECURITY NO.<br>?   |  |                    | 17. INFORMANT<br>LEONARD ANDERSON 2419 E. PRESTON ST.     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Congestive heart failure  |  |  |  |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 week |                    |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>Schizophrenia, Dementia, Stroke  |  |  |  |  |  |   |  |  |   |  |                    |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                    |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |  |                    |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |                    |   |  |
| 22a. I certify that (I) (if this hospital) attended the deceased from 11/15/86, 19, to 11/21/86, 19, that (I) (we) lost<br>saw the deceased alive on 11/21/86, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |   |  |                    |   |  |
| 22b. SIGNATURE<br>Stuart E. Selonick, M.D.   |  |  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  | 22c. DATE SIGNED<br>11/21/86  |  |                    |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>STUART E. SELONICK, M.D.  |  |  |  |  |  | 22e. ADDRESS<br>51 Franklin St Annapolis, Md. 21401   |  |  |   |  |                    |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(IF OTHER)  |  |  | 23b. DATE<br>11-26-86  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO.  |  |                    |   |  |
| 24. FUNERAL DIRECTOR<br>MARCH FUNERAL HOME   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 25 1986  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Anderson-Randall  |  |                    |   |  |

BP

052527



052527

024283 NOV 18 1986

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 2 9 0

REGISTRAR

REG. NO.

|   |   |   |   |   |                          |
|---|---|---|---|---|--------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Joseph A. Aragona</b>                |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>Nov. 11, 1986</b>  |   | 2b. HOUR<br><b>P. M.</b> |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 1, 1906</b>   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>80</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |                          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New Jersey</b>              | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel</b> MD.                                 |   |                          |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Annapolis Convalescent Center</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>School Teacher</b>        |                          |
| 13a. STATE<br><b>New Jersey</b>   | 13b. COUNTY<br><b>Ocean</b>   | 13c. CITY OR TOWN<br><b>Homs River</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>1962 Hovsons Blvd. 08153</b> |                          |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas Aragona</b>             |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Angela Baragona</b>   |   |   |                          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN) <b>Yes</b> |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |   | 17. INFORMANT<br>ADDRESS<br><b>Helen B. Aragona - Same as #13</b> |                          |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cordis ryp arrest**

DUE TO, OR AS A CONSEQUENCE OF

(b) **dementia**

DUE TO, OR AS A CONSEQUENCE OF

(c) **portulacium diu**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **PAGERS James J. Aron**

|  |  |   |  |
|--|--|---|--|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>7</b> , 19 <b>82</b> , to <b>11/11</b> , 19 <b>86</b> , that (we) last saw the deceased alive <b>10/1</b> , 19 <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we) (and) (do not) view the body after death. |  |   |  |
| 22b. SIGNATURE<br><b>Michael J. LaPenta</b>  |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><b>11/12/86</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael J. LaPenta MD</b>  |  | 22e. ADDRESS<br><b>703 GIDDINGS AVE ANNAPOLIS MD 21401</b>  |  |

|  |                                   |  |  |
|--|-----------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>                         | 23b. DATE<br><b>Nov. 15, 1986</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ocean Co. Memorial Park</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Toms River Ocean NJ</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Taylor Funeral Chapel Annapolis, MD</b> |                                   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1986</b>                  |  |
|  |                                   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Aron-Rodriguez</b>            |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return this certificate, with the proper fee, to the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, this medical certificate must be notified at once.

1. 100% Cotton  
2. 100% Cotton  
3. 100% Cotton

4. 100% Cotton  
5. 100% Cotton  
6. 100% Cotton

7. 100% Cotton  
8. 100% Cotton  
9. 100% Cotton

10. 100% Cotton  
11. 100% Cotton  
12. 100% Cotton

13. 100% Cotton  
14. 100% Cotton  
15. 100% Cotton

100% COTTON FIBER

100% COTTON FIBER

024046 NOV

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 3 0 2 9 1  
EST  
REG. NO.

1. FOR STATE REGISTRAR  
1. DECEASED NAME FIRST MIDDLE LAST  
JULIUS WILSON ARNDT JR  
(TYPE OR PRINT)  
2. DATE OF DEATH MONTH DAY YEAR  
NOVEMBER 09, 1986  
2b. HOUR  
525 PM  
3. SEX Male  
4. RACE White  
5. DATE OF BIRTH MONTH DAY YEAR  
March 19, 1925  
6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.  
IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland  
7b. CITIZEN OF WHAT COUNTRY? USA  
8. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐  
9. BALTIMORE CITY OR COUNTY OF DEATH  
ANNE ARUNDEL COUNTY MD.  
10. CITY OR TOWN OF DEATH GLEN BURNIE  
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
NORTH ARUNDEL HOSPITAL  
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic  
12b. KIND OF BUSINESS OR INDUSTRY Dovell & Williams

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  
13a. STATE maryland  
13b. COUNTY A A Co.  
13c. CITY OR TOWN Millersville  
13d. INSIDE CITY LIMITS? YES ☐ NO ☒  
13e. STREET ADDRESS / ZIP CODE 8322 Westside Drive 21108  
14. FATHER'S NAME FIRST MIDDLE LAST  
Julius W. Arndt, Sr.  
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
Nina Ann Kauffman  
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  
No None  
16b. SOCIAL SECURITY NO. 219.18.3322  
17. INFORMANT (Wife) ADDRESS  
Anita H. Arndt Same as #13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) BRAINSTEM INFARCTION.  
DUE TO, OR AS A CONSEQUENCE OF (b) VERTEBROBASILAR THROMBOSIS  
DUE TO, OR AS A CONSEQUENCE OF (c)  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  
19a. DATE OF OPERATION  
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  
20a. AUTOPSY? YES ☐ NO ☐  
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐  
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
P.M. 19  
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  
21d. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK  
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 11-5-1986 to 11-9-1986, that (I) (we) lost saw the deceased alive on 11-9-1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  
22b. SIGNATURE *Nemody M.D.* DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐  
22c. DATE SIGNED  
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARSHAD P. MODY, M.D.  
22e. ADDRESS 14 WELHAM AVE, SUITE 103 GLEN BURNIE, MARYLAND 21061

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  
23b. DATE Nov 13, 1986  
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park  
23d. LOCATION CITY OR TOWN COUNTY STATE  
Glen Burnie A A Co. Md.  
24. FUNERAL DIRECTOR NAME *D. Davis* ADDRESS Singleton Funeral Home Glen Burnie, Maryland  
25a. DATE REC'D. BY REGISTRAR NOV 13  
25b. REGISTRAR'S SIGNATURE *Julia Davidson-Randall*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician only completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.



024640 NOV 20 1986

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 5 3 0 2 7 2  
EST

| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR                              |   |   | 2b. HOUR   |  |
|--|---|---|--|---|---|--|--|
| JOSEPH H ASHMEAD   |   |   | NOVEMBER 11, 1986  |   |   | 1050 PM  |  |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH<br>MONTH DAY YEAR  | 6. AGE (IN YEARS LAST BIRTHDAY)                                  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |  |
| MALE   | WHITE   | SEPT. 23, 1897  | 89 YRS.  |   |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |   |   |  |  |
| NEW JERSEY   | UNITED STATES   |   | ANNE ARUNDEL COUNTY MD.  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY         |  |  |
| GLEN BURNIE  | NORTH ARUNDEL HOSPITAL  |   | MANAGER  |   | MACH. FACTORY                             |  |  |
| 13a. STATE   |   |   | 13b. CITY OR TOWN  |   | 13c. STREET ADDRESS / ZIP CODE            |  |  |
| MARYLAND   |   |   | PASADENA   |   | 401 DUTCHSHIP RD. 21122                   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                    |   |   |  |  |
| JOSEPH ASHMEAD   |   |   | VIOLA BASSETT  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   |   | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS                     |  |  |
| NO   |   |   | 215 03 8773  |   | MRS. DOROTHY ASHMEAD (SAME AS 13a-c)      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PARKINSONISM</u><br>DUE TO, OR AS A CONSEQUENCE OF (c)  |   |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |   |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/10/86</u> , 19 <u>86</u> , to <u>10/11</u> , 19 <u>86</u> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>10/11</u> , 19 <u>86</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If <input checked="" type="checkbox"/> (did) (did not) saw the body after death. |   |   |  |   |   |  |  |
| 22b. SIGNATURE<br><u>John Shavers</u>  |   |   |  | DEGREE<br>ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/><br>PHYSICIAN DIRECTOR PHYSICIAN |   | 22c. DATE SIGNED<br>11/11/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOHN SHAVERS, M.D.  |   |   |  | 22e. ADDRESS<br>518 S. CAMP MEADE RD<br>LINTHICUM, MARYLAND 21090   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |   | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| BURIAL   |   | NOV. 14, 1986   |  | MT. CARMEL CEMETERY   |   | PASADENA ANNE ARUNDEL MD   |  |
| 24. FUNERAL DIRECTOR<br>NAME   |   | 24b. ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE   |  |
| McCully F.H. of Pasadena   |   | 3704 MOUNTAIN RD.<br>PASADENA, MD 21122   |  | NOV 18 1986   |   | <u>John Shavers</u>  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



2012-14 + 2015-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100-101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000-1001-1002-1003-1004-1005-1006-1007-1008-1009-1010-1011-1012-1013-1014-1015-1016-1017-1018-1019-1020-1021-1022-1023-1024-1025-1026-1027-1028-1029-1030-1031-1032-1033-1034-1035-1036-1037-1038-1039-1040-1041-1042-1043-1044-104

0211 22 1111

• J. B. S. HENNINGSEN

025372 NOV 23 1985

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 0 2 7 3

REG. NO.

|   |  |   |   |   |   |  |   |  |  |
|---|--|---|---|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CORA Tempest BUSINSKY</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 24 86</b>                  |   |   | 2b. HOUR<br><b>8:45 AM</b>   |   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 30 14</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.                                    |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>A.A.</b> MD.                              |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Anne Arundel General Hospital</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |
| 13a. STATE<br><b>MD</b>   |  |   | 13b. COUNTY<br><b>AA</b>  |   | 13c. CITY OR TOWN<br><b>Annapolis</b>                   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown Stephens</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown Stevens</b> |   |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, GIVE WAR OR DATES)<br><b>NO</b> |   |  |  |
| 16a. SOCIAL SECURITY NO.<br><b>215-34-9862</b>  |  |   | 17. INFORMANT<br><b>Joseph F. Businsky</b>                              |   |   | 17. ADDRESS<br><b>Same as #13</b>  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.   |  |   |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>       |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                             |  |   |   |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>H. Goldstein</b> M.D.  |  |   |   |   |   | 22c. ADDRESS<br><b>205 Ridgely Ave Annapolis MD</b>                                  |   | 22d. DATE SIGNED<br><b>11/24/86</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  |   | 23b. DATE<br><b>Nov. 24, 1986</b>                                       |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland PG MD</b>                             |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Taylor Funeral Chapel- Annapolis, MD</b>   |  |   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 26 1986</b>                                  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Tracy R. Pender</b>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO.   |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  |  | 2b. HOUR   |  |
| 3. DECEASED NAME FIRST MIDDLE LAST   |  |  |  | Nov. 11, 1986  |  |  |  | 10:04 P.M.   |  |
| Laura Gray Bassette  |  |  |  |  |  |  |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR MONTHS DAYS                              |  |
| Female   |  | Caucasion  |  | May 26, 1901   |  | 85   |  | IF UNDER 24 HRS. HOURS MIN.                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |
| Pennsylvania   |  | U.S.A.   |  |  |  | Anne Arundel Co. MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  | 12b. KIND OF BUSINESS OR INDUSTRY                        |  |
| Severna Park   |  | 480 Severnside Dr.   |  |  |  | Homemaker  |  | Home   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13b. INSIDE CITY LIMITS?   |  | 13c. STREET ADDRESS / ZIP CODE   |  |  |  |
| 13a. STATE COUNTY  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 480 Severnside Dr. 21146   |  |  |  |
| 13a. Maryland A.A. Co.   |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |  |  |
| John Presley Gray  |  |  |  | Ermina Fant  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |  |  |
| no   |  |  |  | 213-74-5295  |  | Reland M. Sanchez Same as Above 13c  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |  |
| IMMEDIATE CAUSE (a) <u>Cerebrovascular failure</u>   |  |  |  |  |  |  |  | 5 years  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>ischemic cerebromyopathy</u>   |  |  |  |  |  |  |  | 3 years  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u>   |  |  |  |  |  |  |  | 5 years  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a-  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?  |  |
|  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
|  |  |  |  | P.M. 19  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/12</u> , 19 <u>80</u> , to <u>11/11</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>11/11</u> , 19 <u>86</u> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death. |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE   |  |  |  | 22c. DATE SIGNED   |  |
| <u>General Oliver M. D.</u>  |  |  |  |  |  |  |  | 11/13/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |  |  |  |  |
| <u>GONARIN CHURCH</u>  |  |  |  | <u>8 E. COR BAYVIEW AVE SEVERNA PARK MD 21146</u>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                  |  |
| Burial   |  |  |  | 11-14-1986   |  | Ft. Lincoln Cem.   |  | Bladensburg PG MD  |  |
| 24. FUNERAL DIRECTOR NAME  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| <u>Baranco</u>   |  |  |  | NOV 14 1986  |  | <u>John Anderson-Pandora</u>   |  |  |  |

*[Faint, mostly illegible handwritten text on lined paper. The text appears to be a memorandum or report, with some words like "subject", "information", and "conclusion" visible. There are several lines of text, some of which are crossed out or heavily faded.]*



026575 DEC 10

FOR  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

3 0 2 9 5

REG. NO.

|   |  |   |  |   |
|---|--|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LILLIE B. DATES</b>                     |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV. 26 1986</b>  |  | 2b. HOUR<br><b>2:05 P</b>                                   |
| 1. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>APR. 3 1890</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>96</b> YRS.           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW JERSEY</b>                    | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL</b> MD.                        |   |
| 10. CITY OR TOWN OF DEATH<br><b>CROWNSVILLE</b>                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FAIRFIELD ARUNDEL Nsg. Ct.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>BOOK KEEPER</b> | 12b. KIND OF BUSINESS, OR INDUSTRY<br><b>MEAT DISTR.</b>    |
| 13a. STATE<br><b>NEW JERSEY</b>   | 13b. COUNTY<br><b>OCEAN CITY</b>   | 13c. CITY OR TOWN<br><b>OCEAN CITY</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET ADDRESS / ZIP CODE<br><b>WESTLEY MANOR 9999</b> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Burley</b>                           |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Joanna Batten</b>   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br><b>138-03-1782</b>  |  | 17. INFORMANT<br><b>Doris Huntsman</b>                      |
|   |  | ADDRESS<br><b>119 St. Andrews Rd.<br/>Severna Park, Md. 21146</b>   |  |   |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>Months</b> |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Metastasis</b>   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>     |  |  |

|  |  |   |   |
|--|--|---|---|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-21</b> 19 <b>78</b> , to <b>11-26</b> 19 <b>86</b> , that (I/we) last saw the deceased alive on <b>10-27</b> 19 <b>86</b> , and that in (my) <del>my</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> <del>did not</del> view the body after death. |  |   |   |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><b>11/26/86</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. Hochman</b>   |  | 22e. ADDRESS<br><b>Severna Park, Md</b>   |   |

|   |                               |   |  |
|---|-------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> | 23b. DATE<br><b>12-1-1986</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Siloam Cem.</b>            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Vineland New Jersey</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>BARRANCO F. H.</b>         |                               | 24b. ADDRESS<br><b>495 RITCHIE Hwy.<br/>SEVERNA PARK, MD. 21146</b> | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 04 1986</b>                      |
|   |                               | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                    |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

05883 1000

NON COLLO LITER

WATERFILL

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Program" and "the" are faintly visible.]*



|   |  |   |   |   |                                    |  |
|---|--|---|---|---|------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>VIOLA Virginia BAUMGARTNER</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 20, 1986</b> |   | 2b. HOUR<br><b>6<sup>P</sup></b> M |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 7 1918</b>  |                                    |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.   |  | 7. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 9b. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel</b> MD.  |   | 10. CITY OR TOWN OF DEATH<br><b>Glen Burnie</b>   |                                    |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>306 Woodleaf Court, Glen Burnie</b>   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Supervisor</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Govt.</b>  |                                    |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>Anne Arundel</b>  |   | 13c. CITY OR TOWN<br><b>Glen Burnie</b>   |                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Bryant</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Effie Yingling</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |                                    |  |
| 16b. SOCIAL SECURITY NO.<br><b>215.03.8880</b>  |  | 17. INFORMANT<br><b>Mrs. Betty Barton</b>   |   | 18. ADDRESS<br><b>Same as above #13</b>   |                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Lung Cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 months</b> |  |   |   |   |                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br>_____   |  |   |   |   |                                    |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                    |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |   |   |                                    |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |                                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                    |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>May 19, 1986</b> to <b>Nov 20, 1986</b> , that (2) (we) last saw the deceased alive on <b>July 28, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (add) did not view the body after death.  |  |   |   |   |                                    |  |
| 22b. SIGNATURE<br><b>Charles Padgett</b>  |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>11/21/86</b>   |                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Charles Padgett</b>   |  | 22e. ADDRESS<br><b>5601 Loch Raven Blvd, Baltimore, Md</b>  |   |   |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Nov. 24, 1986</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>  |                                    |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Dundalk Baltimore MD</b>   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Singleton Funeral Home Glen Burnie, Maryland</b>   |   |   |                                    |  |
| 25a. DATE REC'D BY REGISTRAR<br><b>NOV 25 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |   |                                    |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201


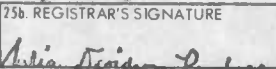
10710

024306

Item: 5 G-622 12/8/86

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |                             |  |   |   |   |   |   |   |
|---|-----------------------------|--|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Joseph F. Ballard Jr.</b>   |                             |  | 2a. DATE KNOWN OF DEATH<br>MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/><br><b>11 5 1986</b> |   |   | 2b. HOUR<br>M <input type="checkbox"/> MIN <input type="checkbox"/> SEC <input type="checkbox"/><br><b>12:35</b>                          |   |   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Caucasian</b> | 5. DATE OF BIRTH<br>MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/><br><b>October 8, 1950</b>            | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>36</b> YRS.  | IF UNDER 1 YR.<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>   | IF UNDER 24 HRS.<br>HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>      | 2c. DATE PRONOUNCED DEAD<br>MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/><br><b>11 5 1986</b> |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ohio</b>  |                             | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel County, MD.</b>   |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>   |                             | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Anne Arundel General Hospital</b> |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Group Manager</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Insurance</b>                               |   |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |                             |  |   | 13b. COUNTY<br><b>Anne Arundel</b>  |   | 13c. CITY OR TOWN<br><b>Crofton</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST <b>Joseph</b> MIDDLE <b>F.</b> LAST <b>Ballard, Sr.</b>  |                             |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Donna</b> MIDDLE <b>A.</b> LAST <b>Tong</b>  |   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>yes</b>   |                             | 16b. SOCIAL SECURITY NO.<br><b>273-50-1951</b>   |   | 17. INFORMANT<br><b>Janis P. Ballard</b>  |   | ADDRESS<br><b>same as 13c</b>   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple injuries</b><br><b>8120</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>(c) _____  |                             |  |   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                             |  |   |   |   |   |   |   |
| 19a. DATE OF OPERATION  |                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><b>NOON P.M. 11 5 1986</b>  |                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>NOON P.M. 11 5 1986</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Driver in auto/truck impact</b>   |   |   |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |                             | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>street</b>   |   | 21f. LOCATION<br>STREET <b>Rt. 450</b><br>CITY OR TOWN <b>Crownsville, A.A.CO, MD.</b><br>COUNTY <b>A.A.CO</b><br>STATE <b>MD.</b>                          |   |   |   |   |
| 22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                             |  |   |   |   |   |   |   |
| ACTUAL SIGNATURE<br>   |                             | TITLE (SPECIFY)<br><b>Assistant</b>  |   | MEDICAL EXAMINER  |   | DATE SIGNED <b>11/6/86</b>  |   |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>William M. Zane, M.D.</b>  |                             | ADDRESS <b>111 Penn St. Balto.MD.</b>  |   |   |   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |                             | 23b. DATE<br><b>Nov 9 1986</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Metropolitan Crematory</b>   |   | 23d. LOCATION<br>CITY OR TOWN <b>Alexandria, Virginia</b><br>COUNTY <b></b><br>STATE <b></b>  |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Beall Funeral Home</b>   |                             | ADDRESS<br><b>5000 Annapolis Road<br/>Bowie, Maryland 21238</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1986</b>   |   | 25b. REGISTRAR'S SIGNATURE<br>                       |   |   |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS OF DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. THIS CERTIFICATE IS VALID FOR 14 DAYS. IF THE DECEASED IS NOT BURIED, CREMATED, OR REMOVED WITHIN 14 DAYS, THIS CERTIFICATE MUST BE RE-EXECUTED. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH THE DEATH CERTIFICATE. PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, OR FOR OTHER PURPOSES. THIS CERTIFICATE IS VALID FOR 14 DAYS. IF THE DECEASED IS NOT BURIED, CREMATED, OR REMOVED WITHIN 14 DAYS, THIS CERTIFICATE MUST BE RE-EXECUTED.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

02436 1111 11

Mr. [unclear] [unclear] [unclear]  
[unclear] [unclear] [unclear] [unclear]  
[unclear] [unclear] [unclear] [unclear]

Mr. [unclear] [unclear] [unclear] [unclear]  
[unclear] [unclear] [unclear] [unclear]  
[unclear] [unclear] [unclear] [unclear]

Mr. [unclear] [unclear] [unclear] [unclear]  
[unclear] [unclear] [unclear] [unclear]  
[unclear] [unclear] [unclear] [unclear]



NOV 10 1961  
FBI  
RECEIVED

Mr. [unclear] [unclear] [unclear] [unclear]  
[unclear] [unclear] [unclear] [unclear]  
[unclear] [unclear] [unclear] [unclear]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

24285 NOV 1985

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |   |
|---|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Edward Milton Davis, Sr</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov-11-1986</b>                          |   | 2b. HOUR<br><b>8:00 A M</b>                                     |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug 14, 1899</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.                                  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                 |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel</b> MD.                    |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>525 Tayman Drive</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Heating &amp; Plumbing Con.</b>                         |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>   |  |   | 13b. CITY OR TOWN<br><b>AA Annapolis</b>   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13d. STREET ADDRESS / ZIP CODE<br><b>525 Tayman Drive 21403</b> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James T. Davis</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Edith Love Kirby</b>           |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>577-16-0155</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>same as #13</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sudden death.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Ischemic cardiomyopathy</b><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. |  |   |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Acromegaly (permanent)</b>   |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11 125 82 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/25</b> 19 <b>82</b> , to <b>11/11</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>11/7</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |
| 22b. SIGNATURE<br><b>George P. Samaras</b>  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>11/11/86</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>George P. Samaras</b>   |  | 22e. ADDRESS<br><b>205 Ridgely Ave Annapolis MD</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>Nov. 12, 1986</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Taylor Funeral Chapel-Annapolis, MD</b>  |  | 24b. LOCATION<br>CITY OR TOWN<br><b>Switzland</b>   |  | 24c. COUNTY<br><b>PG. MD</b>  |   |
| 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Dickinson-Randall</b>  |  |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to the funeral home. Pages 1 and 2 should be filed with 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten notes in cursive script, likely bleed-through from the reverse side of the page. The text is mostly illegible due to fading and bleed-through.

Handwritten notes in cursive script, likely bleed-through from the reverse side of the page. The text is mostly illegible due to fading and bleed-through.

024265 NOV 30

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>John R. BEGLEY</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-13-86</b> |   |  | 2b. HOUR<br><b>1 A.M.</b>   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>09 - 19 - 1904</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>England</b>  |  | 7b. CITIZEN, OF WHAT COUNTRY?<br><b>United States</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel Co.</b> MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Anne Arundel General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Engineer</b>                           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Electrical</b>             |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b> |  |   |  | 13b. CITY OR TOWN<br><b>A.A.</b>  |  | 13c. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  | 13d. STREET ADDRESS<br><b>695 Americana Circle / 21401</b>         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Patrick J. Begley</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Unknown</b>  |  |   |  | 16. ADDRESS<br><b>599 Alston Place<br/>Severna Park, Md. 21146</b> |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>            |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>_____</b>  |  | 17. INFORMANT<br><b>Mary R. Underwood</b>   |  |  |  |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Arteric Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-10</b> , 19 <b>83</b> , to <b>11-13</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>11-11</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Donald Hislop</b>  |  |  |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11-13-86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Donald Hislop M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>31 Robinson Rd. Severna Park Md. 21146</b>   |  |  |  |

|   |  |                                |  |   |  |  |  |
|---|--|--------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                          |  | 23b. DATE<br><b>11-14-1986</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Cem.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ANNAPOULIS A.A. Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>BARBARA F.H. SEVERNA PARK, Md. 21146</b> |  |                                |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1986</b>         |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Underwood</b>                     |  |



054522 1041202



THE LAM

20% COTTON



100% COTTON  
MADE IN U.S.A.  
100% COTTON  
MADE IN U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Elsie Louise Behlke</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 22, 1986</b>            |   |  | 2b. HOUR<br><b>3:45 P.M.</b>   |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 25, 1907</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b>   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>19</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Edgewater</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Pleasant Living Convalescent Ctr.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>AA</b>  |  | 13c. CITY OR TOWN<br><b>Edgewater</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>230 Maryland Avenue 21037</b>   |  |
| 14. FATHER'S NAME<br>(FIRST MIDDLE LAST)<br><b>Leuel L. Brooks</b>   |  | 15. MOTHER'S MAIDEN NAME<br>(FIRST MIDDLE LAST)<br><b>Elizabeth Hose</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, GIVE WAR OR DATES)<br><b>No</b>   |  |  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>212-18-5616</b>   |  | 17. INFORMANT<br><b>William E. Brown</b> ADDRESS<br><b>2402 Nichols Road Annapolis MD 21401</b>   |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe chronic Pulm. Emphysema</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>years</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>immediate</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Senile dementia.</b>  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 1986</b> to <b>Present</b> 19 <b>86</b> , that (I) <b>we</b> lost <b>law</b> the deceased alive on <b>11-17</b> 19 <b>86</b> , and that in (my) <b>last</b> opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                     |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Peter F. Verkouwen</b>  |  |   | DEGREE<br><b>MD</b>  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11-24-86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PETER F. VERKOUWEN</b>   |  |   | 22e. ADDRESS<br><b>1833 Forest Dr. Annapolis MD 21401</b>              |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>Nov. 25, 1986</b>                                      |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Annapolis AA MD</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Taylor Funeral Chapel-Annapolis, MD</b>   |  |   | ADDRESS<br><b>NOV 26 1986</b>  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE<br><b>11-26-86</b>  |  |

1. The first part of the report is a general description of the project and its objectives. It also includes a brief history of the project and a list of the people involved.

2. The second part of the report is a detailed description of the project's progress. It includes a list of the tasks that have been completed and a list of the tasks that are still pending.

3. The third part of the report is a discussion of the project's results. It includes a list of the findings that have been obtained and a list of the conclusions that have been drawn.

4. The fourth part of the report is a list of references. It includes a list of the books, articles, and other sources that have been consulted in the course of the project.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 0 3 0 1

REG. NO.

|   |  |   |   |   |  |   |   |  |  |
|---|--|---|---|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Dorothy L. Beiler  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 30, 1986  |   |  | 2b. HOUR<br>1:30am  |   |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 21, 1918   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Illinois   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel Co. MD.                                    |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Annapolis  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>615 Canal Lane |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>A.A.   |   | 13c. CITY OR TOWN<br>Annapolis  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br>615 Canal Lane /21401  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ernest D. Wood  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Frances Ping   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  |   |   | 16b. SOCIAL SECURITY NO.<br>291-42-1977   |  | 17. INFORMANT<br>ADDRESS<br>Mr. Adam C. Beiler (same as 13)                                     |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |   |   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   | 21g. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 86</u> to <u>Nov. 86</u> , that (I) (we) lost<br>saw the deceased alive on <u>11/20/86</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.        |  |   |   |   |  |   |   |  |  |
| 22b. SIGNATURE<br><u>H. J. Goldstein</u>  |  |   | 22c. DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22d. DATE SIGNED<br><u>12/1/86</u>  |   |  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>H. J. Goldstein  |  |   | 22f. ADDRESS<br>205 Ridgely Ave. Annapolis.   |   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  |   | 23b. DATE<br>12-02-1986   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Crematory                       |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Westview Balt Co. Md. |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>BARRANCO F.H.   |  |   | 24b. ADDRESS<br>495 RITCHIE HWY.<br>SEVERNA PARK, Md. 21146   |   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 4 1986   |   | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randree   |  |

BP

1010

202-0100000

IN REPLY



Received by  
Mr. [illegible]  
[illegible]

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |  |  |   |  |   | 8030302  |  |  |
|---|--|--|---|--|--|--|---|--|---|--|--|--|
| DECLARED NAME<br>(TYPE OR PRINT)  |  |  |   |  | REG. NO.   |  |   |  |   |  |  |  |
| 1. George E Bender  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR M  |  |   |  |   |  |  |  |
| 3. SEX Male   |  | 4. RACE White  |   | 5. DATE OF BIRTH MONTH DAY YEAR June 11, 1935            |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH A.A.Co. MD.                                  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH Pasadena  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 175 2nd. St. Longpoint, Pasa. |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY B.G.E.Co.  |   |  |  |  |
| 13a. STATE Maryland   |  |  |   |  | 13b. COUNTY A.A.Co.  |  | 13c. CITY OR TOWN Pasadena  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 13e. STREET ADDRESS / ZIP CODE Pasadena, Md. 175 2nd, St. Longpoint 2112 |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST George --- Bender   |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Madelyn -- Shaffer  |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes   |  | 16b. SOCIAL SECURITY NO. 1957-1963 213-32-4982   |   | 17. INFORMANT ADDRESS Mrs. Jean C. Bender, Same as above |  |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) nonsmall cell cancer of lung  |  |  |   |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1yr |  |  |
| DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |   |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: malnutrition   |  |  |   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-86, to 11-26, 1986, that (I) (we) last saw the deceased alive on 11-3-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE Barbara A. Conley  |  |  |   |  | DEGREE MD  |  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED 11-26-86                        |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARBARA A. Conley MD  |  |  |   |  | 22e. ADDRESS UMCC 22 S. Greene St Baltimore Md 21201   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation   |  |  | 23b. DATE 11/26/86  |  | 23c. NAME OF CEMETERY OR CREMATORY Security  |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE Md. Catonsville, Balto. Co.  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME Pasadena, Md. 21122 McCully Funeral Home, 3204 Mt. Rd.  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR DEC 0 1 1986   |  | 25b. REGISTRAR'S SIGNATURE Julia Swanson-Pandora                                  |  |   |  |  |  |

022221 CC-218





25556 DEC-28

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |                  |  |  |  |  |  |                                   |  |                                  |  |
|---|--|------------------|--|--|--|--|--|-----------------------------------|--|----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FLORENCE E. BENTON   |  |                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 24 86  |  |  | 2b. HOUR<br>1:15 PM  |  |                                   |  |                                  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>09 30 1895 |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>91 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS |  | 8. IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>A.A. Co. MD.   |                                  |  |
| 10. CITY OR TOWN OF DEATH<br>Glen Burnie  |  |                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>North Arundel Convalescent Center |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  |                                   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Domestic  |                                  |  |
| 13a. STATE<br>Maryland  |  |                  | 13b. CITY OR TOWN<br>Anne Arundel Linthicum  |  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                                   | 13e. STREET ADDRESS / ZIP CODE<br>6313 Homewood Rd., 21090   |                                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Waters  |  |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Hagner   |  |  |  |  |                                   |  |                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  |                  | 16b. SOCIAL SECURITY NO.<br>214-20-5798  |  |  | 17. INFORMANT ADDRESS<br>George E. Benton Same as #13  |  |                                   |  |                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio respiratory arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) ASCEVD<br>DUE TO, OR AS A CONSEQUENCE OF (c) CHF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)<br>arteriosclerosis 035 |  |                  |  |  |  |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                                  |  |
|   |  |                  |  |  |  |  |  |                                   |  |                                  |  |
| 19a. DATE OF OPERATION  |  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |                                   |  |                                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |                                   |  |                                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-12, 19-86, to 11-28, 19-86, that (I) (we) last saw the deceased alive on 11-12, 19-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |                  |  |  |  |  |  |                                   | 22c. DATE SIGNED<br>11 28 86   |                                  |  |
| 22b. SIGNATURE<br>Mustafa C. O. 2 MD  |  |                  | DEGREE<br>M.D.   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |  |                                   |  |                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Mustafa C. O. 2 MD   |  |                  | 22e. ADDRESS<br>605 B & A Blvd SP Md   |  |  |  |  |                                   |  |                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |                  | 23b. DATE<br>11/26/86  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem Pk   |  |                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Elkridge, Howard, Md.  |                                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>McCully Funeral Homes Balto. Md.  |  |                  | 237 E. Patapsco Ave.,<br>ADDRESS   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 0 1 1986  |  |                                   | 25b. REGISTRAR'S SIGNATURE<br>Lisa Gordon-Pandey   |                                  |  |

BP

22220-10-509

REB

DOWN



024045 NOV 4

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 0 3 0 4  
REG. NO. EST

|   |  |  |  |   |   |   |  |   |  |  |  |
|---|--|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MICHAEL BLAKE BLEVINS SR</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 10, 1986</b>   |   |   |  | 2b. HOUR<br><b>602 PM</b>   |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>October 8, 1945</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>41 YRS.</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Engineer</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Rail Road</b>   |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |  |  | 13b. COUNTY<br><b>A A Co.</b>   |   | 13c. CITY OR TOWN<br><b>Glen Burnie</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Bascum Blevins</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Pauline Carli</b>   |   |   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1541 Furnace Ave. 21061</b>                                |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>231.58.6469</b>  |  | 17. INFORMANT (Mother-In-Law)<br><b>Lillian W. Ironmonger</b>   |   |   |  | ADDRESS<br><b>1045 7th Street Glen Burnie, Md. 21061</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOVASCULAR ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>CARCINOMA LUNG</b>  |  |  |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 19 86</b> , to <b>Nov 19 86</b> , that (I) (we) lost saw the deceased alive on <b>Sept 19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                   |  |  |  |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Alpana Goswami</b>   |  |  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ALPANA GOSWAMI, M.D.</b>  |  |  |  |   |   | 22e. ADDRESS<br><b>200 HOSPITAL DRIVE GLEN BURNIE, MARYLAND 21061</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  |  | 23b. DATE<br><b>Nov 14, 1986</b>                                       |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Security Process, Inc</b>            |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Catonsville Balto. Md.</b>          |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Singleton Funeral Home</b>   |  |  |  |   |   | ADDRESS<br><b>Glen Burnie, Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 13</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i> |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 60M 7/B4 (VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

054042 104 14 08

100% COTTON FIBER  
MADE IN U.S.A.  
WASH AND DRY  
TUMBLE DRY

1

MADE IN U.S.A.  
WASH AND DRY

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR   |  | 2b. HOUR   |  |
| DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST   |  | 11 13 86   |  | 1:45 P.M.  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
| FEMALE  |  | CAUCASIAN   |  | MONTH DAY YEAR<br>09 25 87   |  | 99 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                       |  |
| VIRGINIA  |  | U.S.A.  |  |  |  | ANNE ARUNDEL CO. MD.   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  | 12a. USUAL OCCUPATION (TYPE OF BUSINESS, TRADE, OR WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| EDGEWATER   |  | Pleasant Living Convalescent Center   |  | HOUSEWIFE  |  |  |  |
| 13a. STATE  |  | 13b. CITY OR TOWN   |  | 13c. INSIDE CITY LIMITS?   |  | 13d. STREET ADDRESS / ZIP CODE   |  |
| MARYLAND  |  | ANNE ARUNDEL ANNAPOLIS  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 21403<br>9 SILVER WOOD CIRCLE #6   |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  |
| HENRY   |  | RIPPLE  |  | HARRIET  |  | FRAZIER  |  |
| 17. INFORMANT   |  | ADDRESS   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>arterio-sclerotic cardio-vascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>decreased</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>none</u> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>men</u><br><u>years</u> |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 2</u> , 19 <u>84</u> , to <u>11/13</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>10/11</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><u>William C. Weintraub</u><br>DEGREE <u>MD</u><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  | 23a. BURIAL, CREMATION, REMOVAL  |  | 23b. DATE  |  |
| WILLIAM C. WEINTRAUB  |  | 2568 A RIVA RD. ANNAPOLIS, MD.  |  | CREMATION  |  | 11-14-86   |  |
| 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  |
| METROPOLITAN ALEXANDRIA   |  | FAIRFAX VIRGINIA  |  | ROBERT E. EVANS 1212 WEST ST. ANNAPOLIS, MD.   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Rodney</u>                 |  |







059214 NOV 1952

20% COTTON FIBER

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]*

023510 NOV 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 0 3 0 1

REG. NO.

|   |  |  |   |   |  |  |  |
|---|--|--|---|---|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Florence Tressie Boulton   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 02 86 |   |  | 2b. HOUR<br>1815 M   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 9 11  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Alabama   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Annapolis  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Anne Arundel General Hospital |   |   |  | 12. USUAL OCCUPATION<br>(IF WORKING FOR OTHER THAN SELF, GIVE EMPLOYER)<br>Food Service State of MD                        |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY<br>AA  |   | 13c. CITY OR TOWN<br>Annapolis  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Nathaniel Martin Dobbs  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Maryanne Elizabeth Hunter   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>231-10-1929   |  | 17. INFORMANT<br>ADDRESS<br>William H. Sorrell, Jr. Annapolis, MD 21403  |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>Pneumonia<br>Massive Cerebrovascular Accident 2nd |  |  |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/2 1986, to 11/2 1986, that (I) (we) last saw the deceased alive on 11/2 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br>Richard Culgan  |  | DEGREE   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br>11/3/86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Richard Culgan, MD   |  | 22e. ADDRESS<br>707 Giddings Ave. Annapolis, MD  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>Nov. 5, 1986  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Lakemont  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Davidsonville AA MD  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Taylor Funeral Chapel, Annapolis, MD  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV - 6 1986  |   | 25b. REGISTRAR'S SIGNATURE<br>Julia Gordon-Rodney   |  |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP  
DHMH - 16 60M 7/84  
(VRA 15, 4)TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.  
IMPORTANT: If item 21 is marked or item 22 is signed, any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon deposit slip 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. DECEASED NAME  |  |   |  | 2a. DATE OF DEATH   |  |                                       |  | 2b. HOUR   |  |  |  |
|---|--|---|--|---|--|---------------------------------------|--|--|--|--|--|
| (TYPE OR PRINT)   |  |   |  | MONTH DAY YEAR  |  |                                       |  | MONTHS DAYS HOURS MIN.   |  |  |  |
| LEO THEODORE BRADY  |  |   |  | NOVEMBER 08, 1986   |  |                                       |  | 0706 AM  |  |  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE                                |  | 7. IF UNDER 1 YEAR   |  | 7. IF UNDER 24 HRS   |  |
| Male  |  | White   |  | MONTH DAY YEAR  |  | MONTHS DAYS HOURS MIN.                |  |  |  |  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 9. CITIZEN OF WHAT COUNTRY?                             |  | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH |  |  |  |  |  |
| Md.   |  | U.S.A.  |  | Jan. 20, 1926   |  | 60 YRS                                |  | ANNE ARUNDEL COUNTY  |  | MD.  |  |
| 12. CITY OR TOWN OF DEATH   |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |  | 14. USUAL OCCUPATION  |  | 15. KIND OF BUSINESS OR INDUSTRY      |  |  |  |  |  |
| GLEN BURNIE   |  | NORTH ARUNDEL HOSPITAL                                  |  | Mechanic  |  |                                       |  |  |  |  |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 17. INSIDE CITY LIMITS?   |  |                                       |  | 18. STREET ADDRESS / ZIP CODE  |  |  |  |
| 13a. STATE  |  |   |  | 13b. COUNTY   |  |                                       |  | 13c. CITY OR TOWN  |  |  |  |
| Md.   |  |   |  | Anne Arundel  |  |                                       |  | Pasadena   |  |  |  |
| 14. FATHER'S NAME   |  |   |  | 15. MOTHER'S MAIDEN NAME  |  |                                       |  |  |  |  |  |
| John  |  |   |  | Laura   |  |                                       |  | Simpson  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |   |  | 16b. SOCIAL SECURITY NO.  |  |                                       |  | 17. INFORMANT ADDRESS  |  |  |  |
| NO  |  |   |  | 214-22-6014   |  |                                       |  | Cora F. Brady same as 13   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |  |   |  |                                       |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |   |  |   |  |                                       |  |  |  |  |  |
| IMMEDIATE CAUSE (a) <i>cardiac asystole</i>   |  |   |  |   |  |                                       |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>acute myocardial infarction</i>   |  |   |  |   |  |                                       |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>chronic atherosclerotic cardiovascular disease</i>  |  |   |  |   |  |                                       |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>congestive heart failure, emphysema</i>  |  |   |  |   |  |                                       |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |                                       |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |   |  |   |  |                                       |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY   |  |                                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |  |
|   |  |   |  | HOUR A.M. MONTH DAY YEAR  |  |                                       |  |  |  |  |  |
| 21d. INJURY OCCURRED  |  |   |  | 21e. PLACE OF INJURY  |  |                                       |  | 21f. LOCATION  |  |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |                                       |  | STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <i>81</i> to <i>11/8</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>11/7/86</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |                                       |  |  |  |  |  |
| 22b. SIGNATURE  |  |   |  | DEGREE  |  |                                       |  | 22c. DATE SIGNED   |  |  |  |
| <i>James J. Benjamin, M.D.</i>  |  |   |  |   |  |                                       |  | <i>11/8/86</i>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS  |  |                                       |  |  |  |  |  |
| JAMES J. BENJAMIN, M.D.   |  |   |  | 653 OLD MILL ROAD   |  |                                       |  | MILLERSVILLE, MARYLAND 21108   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY    |  | 23d. LOCATION  |  |  |  |
| Burial  |  |   |  | 11-11-86  |  | Cedar Hill Cem.                       |  | CITY OR TOWN COUNTY STATE  |  |  |  |
|   |  |   |  |   |  |                                       |  | Brooklyn Anne Arundel Md.  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |   |  | 25a. DATE RECEIVED BY REGISTRAR   |  |                                       |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| NAME ADDRESS  |  |   |  | 25c. DATE RECEIVED BY REGISTRAR   |  |                                       |  |  |  |  |  |
| Mc Cully F.H. 3294 Mountain Rd. Pasadena, Md.   |  |   |  | 21122   |  |                                       |  | NOV 13 1986  |  |  |  |

024 03 14 03

121

| NO. | NAME                 | ADDRESS                 | CITY         |
|-----|----------------------|-------------------------|--------------|
| 1   | JOHN J. BROWN        | 1234 MAIN ST.           | NEW YORK     |
| 2   | MARY J. WHITE        | 5678 PARK AVE.          | BOSTON       |
| 3   | WILLIAM H. GREEN     | 9010 RIVER RD.          | CHICAGO      |
| 4   | ELIZABETH K. BLACK   | 2345 HILL ST.           | PHILADELPHIA |
| 5   | THOMAS A. GRAY       | 6789 OAK ST.            | ST. LOUIS    |
| 6   | JANE D. HARRIS       | 10110 MAPLE AVE.        | INDIANAPOLIS |
| 7   | CHARLES E. KING      | 12123 CEDAR ST.         | DETROIT      |
| 8   | MICHAEL F. LEE       | 14144 BROADWAY          | NEW YORK     |
| 9   | SARAH G. WALKER      | 16165 CENTRAL AVE.      | ATLANTA      |
| 10  | ROBERT L. YOUNG      | 18186 SPRING ST.        | HOUSTON      |
| 11  | LUCAS M. ADAMS       | 20207 ELM ST.           | PORTLAND     |
| 12  | ANGELA N. BAKER      | 22228 PINE ST.          | SEATTLE      |
| 13  | JOHN P. CARTER       | 24249 WALNUT ST.        | MINNEAPOLIS  |
| 14  | MARGARET R. DAVIS    | 26270 BIRCH ST.         | SPRINGFIELD  |
| 15  | WALTER S. EVANS      | 28291 SAGE ST.          | INDIANAPOLIS |
| 16  | HELEN T. FOSTER      | 30312 HAWTHORNE AVE.    | CHICAGO      |
| 17  | FRANK J. GIBSON      | 32333 SUNDOWN DR.       | NEW YORK     |
| 18  | JOAN K. HAMILTON     | 34354 SUNSHINE BLVD.    | BOSTON       |
| 19  | ALFRED L. JONES      | 36375 RAINBOW AVE.      | PHILADELPHIA |
| 20  | BEATRICE M. KELLY    | 38396 STARLIGHT ST.     | ST. LOUIS    |
| 21  | EDWARD N. LAMONT     | 40417 MOONLIGHT DR.     | INDIANAPOLIS |
| 22  | JOSEPH O. MANN       | 42438 DREAMLAND AVE.    | DETROIT      |
| 23  | MARY P. NICHOLS      | 44459 WONDERLAND ST.    | NEW YORK     |
| 24  | WILLIAM Q. ORR       | 46480 FAIRYLAND BLVD.   | BOSTON       |
| 25  | ANNE R. PETERSON     | 48501 MAGICLAND AVE.    | PHILADELPHIA |
| 26  | CHARLES S. REED      | 50522 ENCHANTMENT ST.   | ST. LOUIS    |
| 27  | JOHN T. RICE         | 52543 FANTASY DR.       | INDIANAPOLIS |
| 28  | MARGARET U. SMITH    | 54564 IMAGINATION AVE.  | CHICAGO      |
| 29  | FRANK V. TAYLOR      | 56585 DREAMS BLVD.      | NEW YORK     |
| 30  | HELEN W. THOMAS      | 58606 WONDERLAND ST.    | BOSTON       |
| 31  | WALTER X. WALKER     | 60627 FAIRYLAND AVE.    | PHILADELPHIA |
| 32  | JOAN Y. WHITE        | 62648 MAGICLAND ST.     | ST. LOUIS    |
| 33  | ALFRED Z. YOUNG      | 64669 ENCHANTMENT DR.   | INDIANAPOLIS |
| 34  | BEATRICE A. ADAMS    | 66690 FANTASY AVE.      | DETROIT      |
| 35  | EDWARD B. BAKER      | 68711 IMAGINATION ST.   | NEW YORK     |
| 36  | JOSEPH C. CARTER     | 70732 DREAMS BLVD.      | BOSTON       |
| 37  | MARY D. DAVIS        | 72753 WONDERLAND AVE.   | PHILADELPHIA |
| 38  | WILLIAM E. EVANS     | 74774 FAIRYLAND ST.     | ST. LOUIS    |
| 39  | ANNE F. FOSTER       | 76795 MAGICLAND DR.     | INDIANAPOLIS |
| 40  | FRANK G. GIBSON      | 78816 ENCHANTMENT AVE.  | CHICAGO      |
| 41  | JOAN H. HAMILTON     | 80837 FANTASY ST.       | NEW YORK     |
| 42  | ALFRED I. JONES      | 82858 IMAGINATION BLVD. | BOSTON       |
| 43  | MARGARET J. KELLY    | 84879 DREAMS AVE.       | PHILADELPHIA |
| 44  | WALTER K. LAMONT     | 86900 WONDERLAND ST.    | ST. LOUIS    |
| 45  | JOSEPH L. MANN       | 88921 FAIRYLAND DR.     | INDIANAPOLIS |
| 46  | MARY M. NICHOLS      | 90942 MAGICLAND AVE.    | CHICAGO      |
| 47  | WILLIAM O. ORR       | 92963 ENCHANTMENT ST.   | NEW YORK     |
| 48  | ANNE P. PETERSON     | 94984 FANTASY BLVD.     | BOSTON       |
| 49  | FRANK Q. REED        | 96005 IMAGINATION AVE.  | PHILADELPHIA |
| 50  | JOAN R. RICE         | 98026 DREAMS ST.        | ST. LOUIS    |
| 51  | ALFRED S. SMITH      | 00047 WONDERLAND DR.    | INDIANAPOLIS |
| 52  | BEATRICE T. TAYLOR   | 02068 FAIRYLAND AVE.    | CHICAGO      |
| 53  | EDWARD U. THOMAS     | 04089 MAGICLAND ST.     | NEW YORK     |
| 54  | JOSEPH V. WALKER     | 06110 ENCHANTMENT BLVD. | BOSTON       |
| 55  | MARY W. WHITE        | 08131 FANTASY AVE.      | PHILADELPHIA |
| 56  | WILLIAM X. YOUNG     | 10152 IMAGINATION ST.   | ST. LOUIS    |
| 57  | ANNE Y. ADAMS        | 12173 DREAMS DR.        | INDIANAPOLIS |
| 58  | FRANK Z. BAKER       | 14194 WONDERLAND AVE.   | CHICAGO      |
| 59  | JOAN A. CARTER       | 16215 FAIRYLAND ST.     | NEW YORK     |
| 60  | ALFRED B. DAVIS      | 18236 MAGICLAND BLVD.   | BOSTON       |
| 61  | MARGARET C. EVANS    | 20257 ENCHANTMENT AVE.  | PHILADELPHIA |
| 62  | WALTER D. FOSTER     | 22278 FANTASY ST.       | ST. LOUIS    |
| 63  | JOSEPH E. GIBSON     | 24299 IMAGINATION DR.   | INDIANAPOLIS |
| 64  | BEATRICE F. HAMILTON | 26320 DREAMS AVE.       | CHICAGO      |
| 65  | EDWARD G. JONES      | 28341 WONDERLAND ST.    | NEW YORK     |
| 66  | JOAN H. KELLY        | 30362 FAIRYLAND BLVD.   | BOSTON       |
| 67  | ALFRED I. LAMONT     | 32383 MAGICLAND AVE.    | PHILADELPHIA |
| 68  | JOSEPH J. MANN       | 34404 ENCHANTMENT ST.   | ST. LOUIS    |
| 69  | MARY K. NICHOLS      | 36425 FANTASY DR.       | INDIANAPOLIS |
| 70  | WILLIAM L. ORR       | 38446 IMAGINATION AVE.  | CHICAGO      |
| 71  | ANNE M. PETERSON     | 40467 DREAMS ST.        | NEW YORK     |
| 72  | FRANK N. REED        | 42488 WONDERLAND BLVD.  | BOSTON       |
| 73  | JOAN O. RICE         | 44509 FAIRYLAND AVE.    | PHILADELPHIA |
| 74  | ALFRED P. SMITH      | 46530 ENCHANTMENT ST.   | ST. LOUIS    |
| 75  | BEATRICE Q. TAYLOR   | 48551 FANTASY DR.       | INDIANAPOLIS |
| 76  | EDWARD R. THOMAS     | 50572 IMAGINATION AVE.  | CHICAGO      |
| 77  | JOSEPH S. WALKER     | 52593 DREAMS ST.        | NEW YORK     |
| 78  | MARY T. WHITE        | 54614 WONDERLAND BLVD.  | BOSTON       |
| 79  | WILLIAM U. YOUNG     | 56635 FAIRYLAND AVE.    | PHILADELPHIA |
| 80  | ANNE V. ADAMS        | 58656 ENCHANTMENT ST.   | ST. LOUIS    |
| 81  | FRANK W. BAKER       | 60677 FANTASY DR.       | INDIANAPOLIS |
| 82  | JOAN X. CARTER       | 62698 IMAGINATION AVE.  | CHICAGO      |
| 83  | ALFRED Y. DAVIS      | 64719 DREAMS ST.        | NEW YORK     |
| 84  | MARGARET Z. EVANS    | 66740 WONDERLAND BLVD.  | BOSTON       |
| 85  | WALTER A. FOSTER     | 68761 FAIRYLAND AVE.    | PHILADELPHIA |
| 86  | JOSEPH B. GIBSON     | 70782 ENCHANTMENT ST.   | ST. LOUIS    |
| 87  | BEATRICE C. HAMILTON | 72803 FANTASY DR.       | INDIANAPOLIS |
| 88  | EDWARD D. JONES      | 74824 IMAGINATION AVE.  | CHICAGO      |
| 89  | JOAN E. KELLY        | 76845 DREAMS ST.        | NEW YORK     |
| 90  | ALFRED F. LAMONT     | 78866 WONDERLAND BLVD.  | BOSTON       |
| 91  | JOSEPH G. MANN       | 80887 FAIRYLAND AVE.    | PHILADELPHIA |
| 92  | MARY H. NICHOLS      | 82908 ENCHANTMENT ST.   | ST. LOUIS    |
| 93  | WILLIAM I. ORR       | 84929 FANTASY DR.       | INDIANAPOLIS |
| 94  | ANNE J. PETERSON     | 86950 IMAGINATION AVE.  | CHICAGO      |
| 95  | FRANK K. REED        | 88971 DREAMS ST.        | NEW YORK     |
| 96  | JOAN L. RICE         | 90992 WONDERLAND BLVD.  | BOSTON       |
| 97  | ALFRED M. SMITH      | 93013 FAIRYLAND AVE.    | PHILADELPHIA |
| 98  | BEATRICE N. TAYLOR   | 95034 ENCHANTMENT ST.   | ST. LOUIS    |
| 99  | EDWARD O. THOMAS     | 97055 FANTASY DR.       | INDIANAPOLIS |
| 100 | JOSEPH P. WALKER     | 99076 IMAGINATION AVE.  | CHICAGO      |

20% COTTON FIBER

1

MADE IN U.S.A.  
100% COTTON FIBER  
WASH & TUMBLE DRY  
DO NOT IRON  
WASH & TUMBLE DRY  
DO NOT IRON

025314 NOV 25 1986

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Mary E. Brass   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>November 21, 1986   |  | 2b. HOUR<br>5:30 A   |
| 3. SEX<br>Female   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>January 19, 1904  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Annapolis   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Annapolis Convelesent Center |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Domestic  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |   |   |  |  |
| 13a. STATE<br>Maryland   | 13b. COUNTY<br>Anne Arundel   | 13c. CITY OR TOWN<br>Pasadena   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>122 Greenland Beach Rd. 21122                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Holsey  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Marklin   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212 01 1283  | 17. INFORMANT ADDRESS<br>Thomas L. Brass (Same as 13a-e)  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Alzheimer's Disease  |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>4 years   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.<br>Decubitus Ulcers   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)                  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT HOME   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/26/83, 19____, to 11/21/86, 19____, that (I) (we) last saw the deceased alive on 11/9/86, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |  |  |
| 22b. SIGNATURE<br>Stuart E. Selonick, M.D.   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br>11/21/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Stuart E. Selonick, M.D.  |   | 22e. ADDRESS<br>57 Franklin St. Annapolis, Md. 21014  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>Nov. 24, 1986  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Olivet Cemetery   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City MD                      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>McCully F.H. of Pasadena   |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 25 1986  |   | 25b. REGISTRAR'S SIGNATURE   |  |

032311 NOV 23 1953

A 0075

INDEXED  
CONFIDENTIAL

112



112  
113  
114  
115  
116  
117  
118  
119  
120



024951 NOV 25

#18a, 2-22a, 6-623, 11/17/86  
FOR med. Ex. / JEG  
STATE REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30310

|  |                              |   |  |   |
|--|------------------------------|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Yvonne Briggs</b>  |                              | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br><input checked="" type="checkbox"/> 10-17-86   |  | 2b. HOUR<br>M   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Black</b>      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2/28/63</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>23 YRS.</b> | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>0 0</b>   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |                              | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 7c. DATE PRONOUNCED DEAD<br><b>11-7-86</b>   |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel County</b>  |  | 2d. HOUR<br>M   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                              | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mount Calvary Cemetery</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |
| 12b. KIND OF BUSINESS OR INDUSTRY  |                              |   |  |   |
| 13a. STATE<br><b>Md.</b>   |                              | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |
| 13e. STREET ADDRESS<br><b>755 W. Lexington St. 21201</b>   |                              |   |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Albert Briggs</b>   |                              | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hilda Gross</b>   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |                              | 16b. SOCIAL SECURITY NO.<br><b>212-80-0195</b>  |  | 17. INFORMANT ADDRESS<br><b>Hilda Morrison 755 W. Lex. St Apt. 603(01)</b>  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Possible drug intoxication</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                              |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.  |                              |   |  |   |
| 19a. DATE OF OPERATION   |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                              | 21b. TIME OF INJURY (Estimated)<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>10 17 19 86</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>subject possibly used drugs</b>   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                              | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>unknown</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>unknown</b>   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . |                              |   |  |   |
| ACTUAL SIGNATURE<br><b>John E. Smialek</b>   |                              | TITLE (SPECIFY)<br><b>Chief</b>   |  | DATE SIGNED<br><b>11-8-86</b>   |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>John E. Smialek, M.D.</b>  |                              | ADDRESS<br><b>111 Penn Street</b>   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>11/15/86</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Westport Md.</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Chas. A. Rice FSPA</b>  |                              | ADDRESS<br><b>1300 Eutaw Place</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 21 1986</b>   |
|  |                              | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Swisher-Lundeen</b>  |  |   |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THESE PLACES: PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

 DHMH - 17  
(VR A15 ME (5))



025590 DEC 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |   |  |   |  |
|---|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Daisy S. Brown</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 21 86</b>  |  | 2b. HOUR<br><b>2:15 PM</b>  |  |
| 3 SEX<br><b>F</b>   | 4. RACE<br><b>B</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 30 1909</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>ANNAPOLIS</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ANNE ARUNDEL GENERAL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>DOMESTIC</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MARYLAND</b>   | 13b. COUNTY<br><b>A.A.</b>  | 13c. CITY OR TOWN<br><b>ANNAPOLIS</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1110 Madison Street Apt. S 4 21403</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIAM BROWN</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>GRACE NEAL</b>  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |   | 17. INFORMANT<br><b>Annapolis, Md. 21403</b><br><b>HELEN THOMAS 1125 Madison St. Apt. S 1</b>  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Known Peritonitis following</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic Monilia &amp; Esophagitis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1984</b> to <b>21 Nov 86</b> that (I) (we) last saw the deceased alive on <b>21 Nov 86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Don B. Lowe</b>  |   | DEGREE  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>24 Nov 86</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Don B. Lowe</b>   |   | 22e. ADDRESS<br><b>Annapolis, Md 21401</b>  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |   | 23b. DATE<br><b>11-26-1986</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PINELAWN MEM. PARK</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Annapolis A.A. Maryland</b>   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>WILLIAM REESE &amp; SONS MORTUARY, P.A. Annapolis, Md. 21401</b>   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 01 1986</b>  |   |  |
|   |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Anderson-Randall</b>  |   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

BP

20X COTTON FIBER

RECEIVED

1951

AMERICAN COTTON FIBER ASSOCIATION

1951

1951

1000 Madison Street

NEW YORK

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

024162 NOV 1986

FOR  
ATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

EST

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ADELE M BUCHAL</b>                                    |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 13, 1986</b> |   |  | 2b. HOUR<br><b>1102 PM</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 4 16</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>               |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home Maker</b>  |  | 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>A.A.</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>213 Franklin Ave 21225</b>  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John L. Williams</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Mollath</b>                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>               |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212-10-4231</b>  |  | 17. INFORMANT ADDRESS<br><b>Donald R. Buchal 313 Burwood Rd Glen Burnie Maryland 21061</b>  |  |  |  |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Septicemia**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **metastatic carcinoma of lung**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

**days****month**

## PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-27</b> , 19 <b>86</b> , to <b>11-13</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>11-13</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Sang C. Do</i>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11-14-86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SANG C. DOH, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>95 AQUAHART RD GLEN BURNIE, MARYLAND 21061</b>  |  |  |  |

|  |  |                              |  |  |  |  |  |
|--|--|------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>               |  | 23b. DATE<br><b>11/17/86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem Park</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY MD<br><b>Glen Burnie A.A.</b> |  |
| 24. FUNERAL DIRECTOR<br><b>George J. Gonce 4001 Ritchie Hwy Balto Md</b> |  |                              |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 17 1986</b>              |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Tison-Rodriguez</i>         |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death be ascertained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon #1. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked on item 38 shows any injury, or other traumatic event, the medical examiner must be notified and advised.



00-23082

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

EST

|  |  |  |   |   |  |  |  |
|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CLYDE Vernon BURNS</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 4, 1986</b> |   |  | 2b. HOUR<br><b>205 AM</b>  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 28, 1908</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78 YRS</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Manager</b>   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>A A Co.</b>  |   | 13c. CITY OR TOWN<br><b>Glen Burnie</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John V. Burns</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth C. Reinhart</b>  |   | 13e. STREET ADDRESS / ZIP CODE<br><b>409 Central Ave. S.W. 21061</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215.05.8198</b>  |   | 17. INFORMANT (wife)<br><b>Mrs. Ruth Burns</b>  |  | ADDRESS<br><b>Same as 13</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Concessive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct. 30, 1986</b> to <b>Nov. 4th, 1986</b> , that (I) (we) last saw the deceased alive on <b>Nov. 3rd, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                 |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Charles J. Wu, M.D.</b>   |  | DEGREE   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>11/4/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHARLES J. WU, M.D.</b>  |  | 22e. ADDRESS<br><b>7845 OAKWOOD ROAD, SUITE 204<br/>GLEN BURNIE, MARYLAND 21061</b>  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Nov 6, 1986</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie A A Co. Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Singleton Funeral Home</b>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV - 5 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the other certifying official, it should be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. Pages 1 and 2 should be filed with the funeral director. Page 3 should be filed with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



00-23032

UNITED STATES DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

CONFIDENTIAL

100-23032-100

11/1/80

CONFIDENTIAL

11/1/80

023307 NOV 1986

FGR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 5 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  | REG. NO. |  |
|---|--|--|--|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Sylvia</u> <u>Butler</u>   |  |  |  | 2a. DATE OF DEATH<br>MONTH <u>11</u> DAY <u>01</u> YEAR <u>86</u>                    |          |  |
| 3. SEX<br><u>F</u>  |  | 4. RACE<br><u>W</u>  |  | 5. DATE OF BIRTH<br>MONTH <u>5</u> DAY <u>18</u> YEAR <u>29</u>                      |          |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><u>W. Virginia</u>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>57</u> YRS.                                    |          |  |
| 10. CITY OR TOWN OF DEATH<br><u>Annapolis</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Anne Arundel Gen. Hosp.</u>                    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Anne Arundel County</u> MD.               |          |  |
| 13a. STATE<br><u>Md.</u>  |  | 13b. CITY OR TOWN<br><u>A. Arundel</u>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |          |  |
| 14. FATHER'S NAME<br>FIRST <u>Md.</u> MIDDLE <u>A. Arundel</u> LAST <u>Arnold</u>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>Mr. Jimmy Hall</u> MIDDLE <u>Glen Burnie</u> LAST <u>Md.</u>  |  | 17. INFORMANT ADDRESS<br><u>522 Delmar Ave.</u>                                      |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <u>No</u>  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS<br><u>522 Delmar Ave.</u>                                      |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cong Cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Breast vs</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>1 DAY</u>   |  |  |  |  |          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)        |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/1</u> 19 <u>86</u> , to <u>11/1</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>11/1</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.        |  |  |  |  |          |  |
| 22b. SIGNATURE<br><u>Jacob E. Teitzerbaum</u>   |  | DEGREE <u>MD</u><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS<br><u>139 old Locum 151. n21494</u>   |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <u>Removal</u>   |  | 23b. DATE<br><u>11-3-86</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY   |          |  |
| 24. FUNERAL DIRECTOR<br>NAME <u>Anatomy Board</u>   |  | ADDRESS <u>Balto., Md.</u>   |  | 25a. DATE REC'D. BY REGISTRAR <u>NOV 06 1986</u>                                     |          |  |
|   |  |  |  | REGISTRAR'S SIGNATURE <u>Juha Davidson</u>   |          |  |

BP

053905 NOV 45 30

9/45 15 VI

10

11

12

13

14

15

16

17

NOV 15 1945

NOV 16 1945

NOV 17 1945

NOV 18 1945

NOV 19 1945

NOV 20 1945

024028 NOV 1986

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 3 0 3 1 2

FOR  
1- STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |  |  |  |
|--|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>RUBY L. CASAMENTO</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 12, 1986</b> |  |  | 2b. HOUR<br><b>8:40 AM</b>   |  |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>WHITE</b>                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MARCH 24, 1924</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>KENTUCKY</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>LINTHICUM</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>525 HAWTHORNE ROAD</b>                      |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>INSPECTOR</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MFG.</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |   |   | 13b. COUNTY<br><b>ANNE ARUNDEL</b>   |  | 13c. CITY OR TOWN<br><b>LINTHICUM</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>BENJAMIN PRIDEMORE</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>NANNIE SMITH</b>                 |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br><b>404-28-2158</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>PHILIP CASAMENTO 525 HAWTHORNE ROAD 21090</b>         |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>gallbladder cancer metastatic</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>cancer of the common bile duct</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>85</b> , to <b>Nov</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>Nov 12</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                            |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Marie Dobyns MD</b>   |  |   |   | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>11/12/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. MARIE DOBYNS, M.D.</b>   |  |   |   | 22e. ADDRESS<br><b>2822 HOLLINS FERRY ROAD</b>                                       |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>11/15/86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE CEMETERY</b>                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>DORSEY HOWARD MARYLAND</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>AMROSE FUNERAL HOME 1328 SULPHUR SPRING ROAD</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1986</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Lia Davidson-Randall</b>  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

|  |  |   |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|---|--|--|--|--|--|
| FOR<br>1- STATE<br>REGISTRAR   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 6 3 0 3 1 0<br>REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LORETTA CLAIRE CASEY</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-2-86</b>   |  |   |  | 2b. HOUR<br><b>7:55</b> P M  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 13, 1933</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>53</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel County</b> MD.                          |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Anne Arundel General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Registered Nurse</b>     |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>P.G.Co. Gov't.</b> |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Pr. George's</b>  |  | 13c. CITY OR TOWN<br><b>Bowie</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>12011 Tempo Lane 20715</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Nealis</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Cambell</b>  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>---</b>   |  | 17. INFORMANT<br><b>Joseph J. Casey</b>   |  | ADDRESS<br><b>12011 Tempo Lane Bowie, MD 20715</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>LYMPHOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:   |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/85</b> , 19____, to <b>11/2/86</b> , 19____, that (we) last saw the deceased alive on <b>11/2/86</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (we did not) view the body after death.        |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Stanley A. Watkins, Jr.</b>   |  |   |  | DEGREE<br><b>M.D.</b>   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/3/86</b>   |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Stanley P. Watkins, Jr., M. D.</b>   |  |   |  | 22e. ADDRESS<br><b>51 Franklin Street Annapolis, MD 21401</b>   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>NOV 5, 1986</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Maryland Veterans Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville, Anne Arundel, MD</b>              |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Beall Funeral Home</b>  |  |   |  | 16000 Annapolis Road<br>Bowie, MD 20715-3043  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 5 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

00000000

1993, 2000.

One-Dimensional

• *Geometrische Optik*

mol.

345

Yes

518-45-115



024019 NOV

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove content paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as above.

| 1. STATE REGISTRAR   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  | 8 6 3 0 3 1 7  |  | REG. NO.  |  | EST  |  |
|--|--|--|--|--|--|---|--|--|--|
| 1a. DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR  |  | A M  |  |
| MARY ELLEN CAWOOD  |  |  |  | NOVEMBER 10, 1986  |  | 6:50  |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  |
| Female   |  | White  |  | October 1, 1938  |  | 48 YRS.   |  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |
| Tennessee  |  | United States  |  |  |  | ANNE ARUNDEL COUNTY MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |
| GLEN BURNIE  |  | NORTH ARUNDEL HOSPITAL   |  | Homemaker  |  | Home  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE                                 |  |
| Maryland   |  | Anne Arundel   |  | Glen Burnie  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 406 Rogers Ave 21061   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO   |  | 17. INFORMANT ADDRESS  |  |
| Benjamin   |  | Willie   |  | No   |  | 411 78 4199   |  | Bonnie Workman (Same as 13a-e)                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | 19. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  | Advanced Uterine Cancer  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  | (b)  |  |  |  |   |  | 1 year   |  |
| (c)  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |  |  |  |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |  |   |  |  |  |
|  |  | P.M. 19  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
|  |  |  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-5, 1986, to 11-10, 1986, that (I) (we) last saw the deceased alive on 11-9, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED  |  |  |  |
|  |  | MD.  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  | 7845 OAKWOOD ROAD #205   |  |   |  |  |  |
| LONG S. HSU, M.D.  |  |  |  | GLEN BURNIE, MARYLAND 21061  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |  |  |
| Burial   |  | Nov. 14 '86  |  | Woodlawn Cemetery  |  | Jelico Clayborne TN   |  |  |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |  |  |
| McCurry Funeral Home   |  | NOV 13 1986  |  | Julia Davidson-Randall   |  |   |  |  |  |

11-11

11-11-11

11-11-11

11-11-11

11-11-11

024010

NOV 14 1986

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 30318

FOR STATE REGISTRAR

|  |   |   |  |  |  |
|--|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Joseph Benjamin Chambers  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>Nov 4 1986                             |  | 2b. HOUR<br>P.M.   |
| 3. SEX<br>Male   | 4. RACE<br>B  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Dec 24 1902  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS.                                     | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>md  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>A.A. CO MD.                        |  |  |
| 10. CITY OR TOWN OF DEATH<br>ANNAPOLIS   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>101 HOLECLAW ST |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Chauffeur |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br>md   |   | 13b. COUNTY<br>A.A.   | 13c. CITY OR TOWN<br>ANNAPOLIS   | 13d. STREET ADDRESS / ZIP CODE<br>927 Spa Road 21401                           |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Issaac Chambers   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Janie Snowden   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>yes   |   | 16b. SOCIAL SECURITY NO.<br>1923-1927 218-30-7309   |  | 17. INFORMANT ADDRESS<br>Rosemarie Taylor 101 HOLECLAW ST                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                    |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>IMMEDIATE  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 12</u> , 19 <u>88</u> , to <u>Sept 4</u> , 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>Sept 4</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |  |  |  |
| 22b. SIGNATURE<br><u>John D. Jackson</u>   |   | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>11-7-86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOHN D JACKSON  |   | 22e. ADDRESS<br>1837 FOREST DR ANNAPOLIS MD 21401   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  | 23b. DATE<br>Nov 10, 1986   | 23c. NAME OF CEMETERY OR CREMATORY<br>md Veterans Cemetery  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Crownsville A.A. md                 |  |
| 24. FUNERAL DIRECTOR NAME<br>C. E. Hicks   |   | ADDRESS<br>1922 Forest Drive  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 13 1986                                   | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers, page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be completed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |  |                       |  |
|--|--|--|---|--|-----------------------|--|
| DECEASED NAME<br>(TYPE OR PRINT)<br>Helen B. Charin  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov. 4, 1986 |  | 2b. HOUR<br>6:45 P.M. |  |
| 3. SEX<br>F  |  | 4. RACE<br>W   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>APRIL 23 1917  |                       |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>69  |  | 7. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel Co. MD.           |   | 8. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>YRS.   |                       |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York   |  | 10. CITY OR TOWN OF DEATH<br>Annapolis                                 |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Anne Arundel Gen. Hosp. |                       |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>12a. STATE Md.   |  | 12b. CITY OR TOWN<br>A.A. Co. Shady Side                               |   | 12c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                      |                       |  |
| 13. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Christian F. Bruseke   |  | 14. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Janet Rodger          |   | 15. STREET ADDRESS / ZIP CODE<br>1466 Nieman Rd. 20764   |                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br>n/a        |   | 17. INFORMANT<br>ADDRESS<br>William S. Charin same as 13   |                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ca Brist</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a |  |  |   |  |                       |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |                       |  |
| 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1982</u> , 19____, to <u>11/4/86</u> , 19____, that (I) (we) last saw the deceased alive on <u>11/4/86</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.  |  |  |   |  |                       |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>STANLEY WATKINS   |  | 22c. DATE SIGNED<br>11/4/86  |   | 22d. ADDRESS   |                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>CREMATION   |  | 23b. DATE<br>11/5/86   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>WESTVIEW CREMATORY   |                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>HARDESTY FUNERAL HOME 12 RIDGELY AVE. ANN  |  | 24a. DATE REC'D. BY REGISTRAR<br>NOV 5 1986                            |   | 24b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |                       |  |

1  
(

CHURCHILL  
1914

53583 11-102

*[Faint, mostly illegible handwritten notes and sketches on lined paper. Some visible words include "Tomb", "C", "D", "E", "F", "G", "H", "I", "J", "K", "L", "M", "N", "O", "P", "Q", "R", "S", "T", "U", "V", "W", "X", "Y", "Z".]*

1000

00-21162

Items, 1,8,&15, G-621 by Mo. STATE OF MARYLAND  
 1- FOR DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 REGISTRAR MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30320

|   |  |  |  |   |  |   |  |  |  |                  |  |                          |  |       |  |      |  |          |  |
|---|--|--|--|---|--|---|--|--|--|------------------|--|--------------------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN OF DEATH                      |  | ESTIMATED        |  | MONTH                    |  | DAY   |  | YEAR |  | 2b. HOUR |  |
| WILLIAM   |  | R.   |  | CHRISTIAN   |  |   |  | 9  |  | 25               |  | 1986                     |  |       |  |      |  |          |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.                               |  | IF UNDER 24 HRS. |  | 7c. DATE PRONOUNCED DEAD |  | MONTH |  | DAY  |  | YEAR     |  |
| MALE  |  | WHITE  |  | 09-11-1944  |  | 42 YRS.   |  |  |  |                  |  | 10                       |  | 6     |  | 1986 |  | 10:05 AM |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | NEVER MARRIED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH         |  |                  |  |                          |  |       |  |      |  |          |  |
| ANNAP. Md.  |  | UNITED STATES  |  | WIDOWED   |  | DIVORCED  |  | Anne Arundel Co.                             |  |                  |  |                          |  |       |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |                  |  |                          |  |       |  |      |  |          |  |
| Odenton   |  | woods-Rt. 175 & Ridge Rd.  |  | ?   |  |   |  |  |  |                  |  |                          |  |       |  |      |  |          |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                          |  |                  |  |                          |  |       |  |      |  |          |  |
| Md.   |  | A.A.   |  | ARNOLD  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 780 N. LAKEVIEW DR. / 21012                  |  |                  |  |                          |  |       |  |      |  |          |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS                                      |  |                  |  |                          |  |       |  |      |  |          |  |
| BILLY   |  | D. CHRISTIAN   |  | 212-44-2890   |  | AUDREY FISCHBACH  |  | (SAME AS 13)                                 |  |                  |  |                          |  |       |  |      |  |          |  |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |  | 18b. SOCIAL SECURITY NO.   |  | 18c. INFORMANT  |  | ADDRESS   |  |  |  |                  |  |                          |  |       |  |      |  |          |  |
| YES   |  | VIETNAM  |  | 212-44-2890   |  | AUDREY FISCHBACH  |  | (SAME AS 13)                                 |  |                  |  |                          |  |       |  |      |  |          |  |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | PART I DEATH WAS CAUSED BY:  |  | IMMEDIATE CAUSE (a)   |  | Multiple gunshot wounds (unspecified weapon)                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                  |  |                          |  |       |  |      |  |          |  |
|   |  |  |  |   |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  |  |  |                  |  |                          |  |       |  |      |  |          |  |
|   |  |  |  |   |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  |  |  |                  |  |                          |  |       |  |      |  |          |  |
|   |  |  |  |   |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  |  |  |                  |  |                          |  |       |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |  |  |   |  |   |  |  |  |                  |  |                          |  |       |  |      |  |          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  |   |  |  |  |                  |  |                          |  |       |  |      |  |          |  |
|   |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |   |  |  |  |                  |  |                          |  |       |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH      |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |  |  |                  |  |                          |  |       |  |      |  |          |  |
|   |  | ? P.M. 9-26-1986   |  | Subject shot.   |  |   |  |  |  |                  |  |                          |  |       |  |      |  |          |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION   |  |   |  |  |  |                  |  |                          |  |       |  |      |  |          |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | woods  |  | Rt. 175 & Ridge Rd., Odenton, Anne Arundel, MD                                |  |   |  |  |  |                  |  |                          |  |       |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on   |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion   |  |   |  |   |  |  |  |                  |  |                          |  |       |  |      |  |          |  |
| death resulted from   |  | Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |  |  |                  |  |                          |  |       |  |      |  |          |  |
| ACTUAL SIGNATURE  |  | TITLE (SPECIFY)  |  | DATE SIGNED   |  |   |  |  |  |                  |  |                          |  |       |  |      |  |          |  |
| Charles P. Kokes, M.D.  |  | M.D. Assistant MEDICAL EXAMINER  |  | 10-6-86   |  |   |  |  |  |                  |  |                          |  |       |  |      |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  | ADDRESS  |  |   |  |   |  |  |  |                  |  |                          |  |       |  |      |  |          |  |
| Charles P. Kokes, M.D.  |  | 111 Penn St., Balto., MD 21201   |  |   |  |   |  |  |  |                  |  |                          |  |       |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  |  |  |                  |  |                          |  |       |  |      |  |          |  |
| CREMATION   |  | 10-10-1986   |  | WESTVIEW MEM.   |  | WESTVIEW BRT Co   |  |  |  |                  |  |                          |  |       |  |      |  |          |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |  |  |                  |  |                          |  |       |  |      |  |          |  |
| BARRANCO F.H.   |  | OCT 16 1986  |  | SEVERNAPARK, Md. 21146  |  |   |  |  |  |                  |  |                          |  |       |  |      |  |          |  |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))



1950-1951

1952-1953

1954-1955

1956-1957



1958-1959

1960-1961

1962-1963

1964-1965

1966-1967

1968-1969

1970-1971

1972-1973

1974-1975

025209 NOV 25 06

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 0 3 0 3 2 1

|  |  |  |  |   |  |  |   |  |  |
|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOHN WESLEY COLBERT</b>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>18</b> YEAR <b>1986</b>      |   |  | 2b. HOUR<br><b>M</b>   |   |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>8</b> YEAR <b>1937</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>49</b>   |   | 7. IF UNDER 1 YEAR<br>MONTHS <b>YRS.</b> DAYS <b>HOURS</b> MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>ANNAPOLIS</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>55 Clay Street</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY<br><b>A.A.</b>   |   | 13c. CITY OR TOWN<br><b>ANNAPOLIS</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST <b>HILLARY</b> MIDDLE <b>COLBERT</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MARTHA</b> MIDDLE <b>ISSAC</b> LAST |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |   |  |  |
| 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT<br><b>Annapolis, Md. 21401</b>                             |   |  | 17. MARY ELLEN BIAS 55 Clay Street   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (d), stating the underlying cause lost.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>min</b><br><b>hour</b> |  |  |  |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>   |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                         |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>        |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/12/86</b> to <b>8/19/86</b> , that (I) (we) lost <b>8/19/86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>William C. Weintraub</b>  |  |  | DEGREE<br><b>MD</b>  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>11/21/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>William C. Weintraub</b>   |  |  | 22e. ADDRESS<br><b>2568 A Rock Rd. Annapolis, Md. 21401</b>              |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>11-22-1986</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PINELAWN MEM. PARK</b>                |  | 23d. LOCATION<br>CITY OR TOWN <b>Annapolis</b> COUNTY <b>A.A.</b> STATE <b>Maryland</b>         |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>WILLIAM REESE &amp; SONS MORTUARY</b> ADDRESS <b>821 West Street, Annapolis, Md. 21401</b>   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 24 1986</b>                      |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia</b>   |   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been issued, the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. The permit must be given to the funeral director within 24 hours after death. The State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 16 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

BP

3031 72 11

00000

00000

0000

04

00000

0000

0000

00000

00000

0000

0000

00000

00000

00000

00000

0000

00000

00000

00000

0000

00000

00000

00000

00000

00000

00000

00000

00000



023512 NOV 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove the registration stamp. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal, or other disposition of the body.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |   |  |   |  |  |
|--|--|---|--|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Mary Lucille Conley</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Nov 5, 1986</b>                 |   |   | 2b. HOUR<br><b>12:55A.M.</b>   |   |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>July 13, 1919</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.  |   | 7. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel</b> MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Anne Arundel General Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>AA</b>  |  | 13c. CITY OR TOWN<br><b>Arnold</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 13e. STREET ADDRESS / ZIP CODE<br><b>943 Forest Drive 21012</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Albert Dean</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Verle</b>   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>-</b>   |  | 17. INFORMANT<br><b>Robert L. Conley</b>  |   | ADDRESS<br><b>Same as #13</b>  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral aneurysm accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1<br><b>probable breast cancer &amp; possible metastasis to brain</b>  |  |   |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 4</b> , 19 <b>86</b> , to <b>Nov. 5</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>Nov 4</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.           |  |   |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>M. Lucille</b>  |  |   | DEGREE   |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>11/5/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. ANTONIA PLUCIS</b>  |  |   |  |   | 22e. ADDRESS<br><b>1521 Ritchie Highway, Arnold, MD</b> |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  |   | 23b. DATE<br><b>Nov 6, 1986</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Switland PG MD</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Taylor Funeral Chapel Annapolis, MD</b>   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV - 6 1986</b>    |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randee</b>          |  |  |

BP

2% COTTON FIBER

1.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return this certificate to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |   |  |   |  |
|--|--|--|--|---|---|---|--|---|--|
| <div style="text-align: right;">8 0 3 0 3 2 3</div> <div style="text-align: left;">242286 NOV 19 86</div>  |  |  |  |   |   |   |  |   |  |
| <div style="text-align: center;">FOR<br/>1 - STATE<br/>REGISTRAR</div>   |  |  |  |   |   |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Pota Conits</b>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 9 86</b>                         |   |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 15 1889</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>97</b> YRS  |  | 2b. HOUR<br><b>8 35</b> M   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Greece</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>A.A.</b> MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Crownsville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Fairfield Nursing Center</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>house wife</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>home</b>  |  |
| 13a. STATE<br><b>md</b>  |  | 13b. COUNTY<br><b>A.A.</b>   |  | 13c. CITY OR TOWN<br><b>Glen Burnie</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>6654 Roberts Ct. Burwood Garden 21061</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maria Conides</b>         |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>362-98-6626</b>                                |   | 17. INFORMANT<br><b>Jack Kontgias - Bethesda, MD 20846</b>             |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ascud</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>5 years</b>  |  |  |  |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>2 years</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>none</b>  |  |  |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/5</b> , 19 <b>80</b> , to <b>11/9/86</b> , 19 <b>86</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/8/86</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>R.M. McLaughlin, M.D.</b>   |  |  |  |   | DEGREE<br><b>M.D.</b>   |   |  | 22c. DATE SIGNED<br><b>11/9/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R.M. McLaughlin, MD</b>  |  |  |  |   | 22e. ADDRESS<br><b>3708 Mountain Rd. Pasadena, Md. 2122</b>                   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>Nov. 13, 1986</b>                                      |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Demetrius</b>                    |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Annapolis A.A. MD</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Taylor Funeral Chapel - Annapolis MD</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1986</b>                           |   | 25b. REGISTRAR'S SIGNATURE<br><b>Lisa Tindon-Randall</b>               |   |  |

BP \_\_\_\_\_

UNITED STATES

NAVY

RECEIVED





5589 DEC-2 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

EDT

|   |  |   |  |   |   |  |  |   |  |
|---|--|---|--|---|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>HARRY . CONWAY   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 23, 1986   |   |   | 2b. HOUR<br>11 30 AM   |  |   |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>BLACK  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 26 1887   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>99 YRS.                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ANNE ARUNDEL COUNTY MD.                |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>GLEN BURNIE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NORTH ARUNDEL HOSPITAL |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>MARYLAND  |  |   | 13b. COUNTY<br>A.A.  |   | 13c. CITY OR TOWN<br>ODENTON  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST HARRY MIDDLE LAST CONWAY   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST TULIP MIDDLE LAST CLARK  |   |   | 13e. STREET ADDRESS / ZIP CODE<br>1385 Galloway Road 21113                     |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-09-9582   |   | 17. INFORMANT<br>Annapolis, Md. 21401<br>EUGENE LONG 882 Marengo Road |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CONGESTIVE HEART FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ASPIRATION PNEUMONIA</u>  |  |   |  |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>SEVERE HYPOTHYROIDISM, SEVERE MALNUTRITION</u>   |  |   |  |   |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-9-</u> 19 <u>86</u> , to <u>11-20-</u> 19 <u>86</u> , that (I) (we) lost<br>saw the deceased alive on <u>11-20-</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |  |  |   |  |
| 22b. SIGNATURE<br><u>George Kirian</u>  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED<br><u>11-25-86</u>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GEORGE KIRIAN, M.D.  |  |   | 22e. ADDRESS<br>14 WELHAM AVENUE, SUITE 101<br>GLEN BURNIE, MARYLAND 21061   |   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |   | 23b. DATE<br>11-26-1986  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>MACEDONIA CHURCH CEME.          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ODENTON A.A. MARYLAND                  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME WILLIAM REESE & SONS MORTUARY, P.A.<br>ADDRESS Annapolis, Md. 21401  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 01 1986                          |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Seider-Randall</u>                            |   |  |

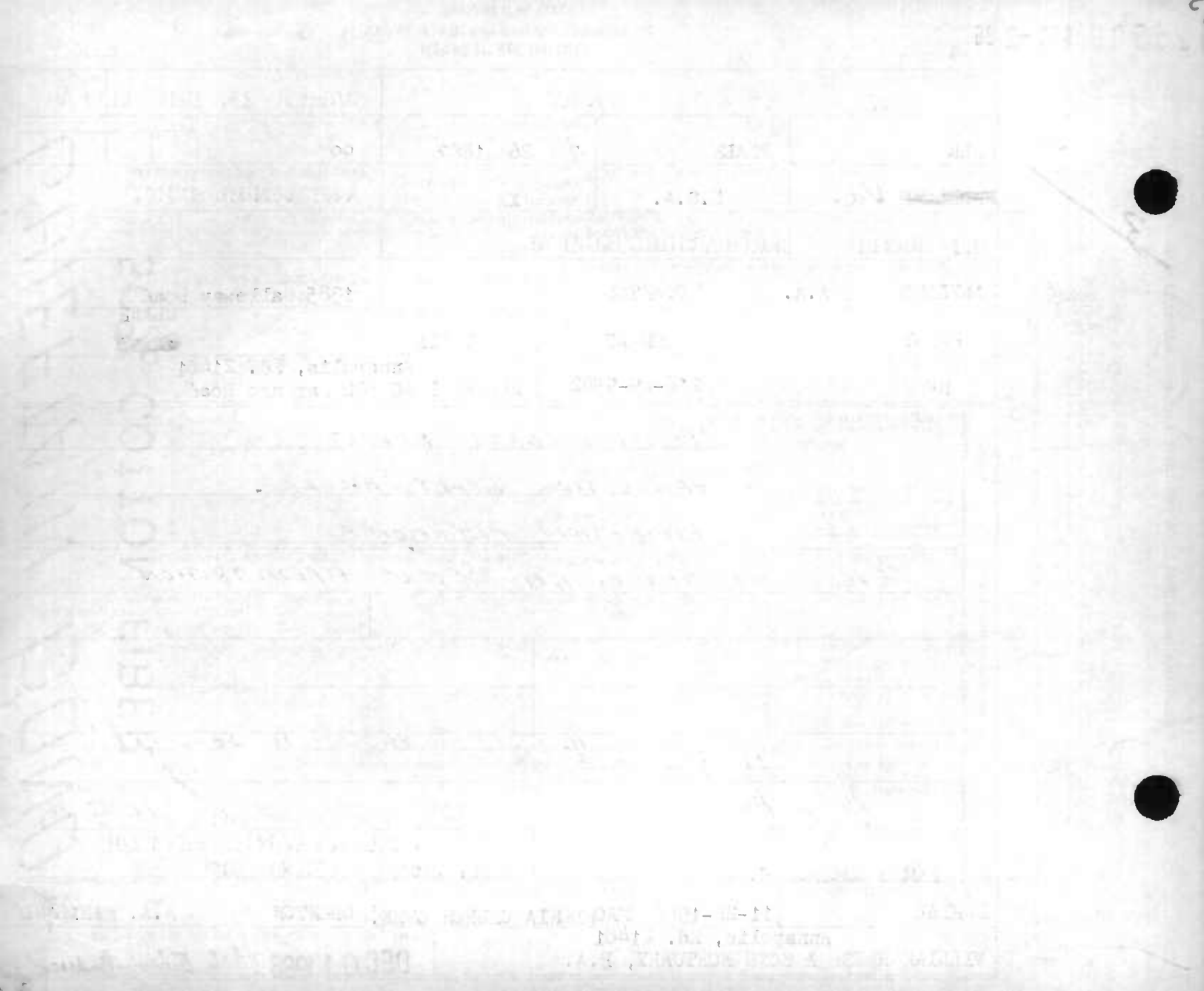
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |   |   |  |
|---|--|--|--|---|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Elizabeth Estelle Cschenk  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 5, 1986                |   |  | 2b. HOUR<br>3:30 P <sub>M</sub>   |   |   |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>August 14, 1918   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel Co. MD.  |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Annapolis  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Anne Arundel General Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ret. Secetary   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Insurance Co.  |   |  |
| 13a. STATE<br>Maryland  |  |  | 13b. COUNTY<br>A A co.   |   | 13c. CITY OR TOWN<br>Annapolis   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br>1104 River Bay Road 21401 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Henry Cschenk   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Bartell      |   |  |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A   |  | 17. INFORMANT (Cousin)<br>Mr. Henry Remmers   |  | ADDRESS 4609 Drexel Road<br>College Park, Md. 20740   |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Breast CA   |  |  |  |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>10 years   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |   |  |   |   |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 19d. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>11/5/86                   |   |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/7/86, 19, to 11/5/86, 19, that (I) (we) lost<br>saw the deceased alive on 11/5/86, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |   |   |   |  |
| 22b. SIGNATURE<br>Stuart E. Selowick, M.D.  |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>11/5/86   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Stuart E. Selowick, M.D.   |  |  |  |   |  | 22e. ADDRESS<br>51 Franklin St. Annapolis, Md 21401   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  | 23b. DATE<br>Nov 8, 1986   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Louden Park Cemetery                     |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                                     |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Singleton Funeral Home Glen Burnie, Maryland  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 10 1986  |   | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked as item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove color-coded tabs. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 3 0 3 2 0

REG. NO.

|   |  |  |  |   |  |  |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST   |  | 2b. DATE OF DEATH  |  | MONTH DAY YEAR   |  | 2c. HOUR   |  |
|   |  | Mary Jane Curtin   |  |   |  | 11 15 86   |  |  |  | 12:30A M   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS  |  |
| Female  |  | White  |  | June 1, 1930  |  | 56   |  | MONTHS DAYS  |  | HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |  |  |
| Washington D.C.   |  | USA  |  |   |  | ANNE ARUNDEL MD.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| ANNAPOLIS   |  | ANNE ARUNDEL GENERAL HOSP.   |  |   |  |  |  | Housewife  |  | Household  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |  |  |  |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS / ZIP CODE   |  |  |  |
| MARYLAND  |  | A. ARUNDEL   |  | EDGEMONT  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 1411 Shore Dr. 21037   |  |  |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |  |  |  |  |
| John FERGUSON   |  |  |  | Nettie Valentine  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | ADDRESS  |  |  |  |
| No  |  |  |  | N-A   |  | Edward F. Curtin   |  | # 13e  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |   |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) ALCOHOLIC CIRRHOSIS OF THE LIVER  |  |  |  |   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) WITH PORTAL HYPERTENSION   |  |  |  |   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  |   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |  |  |  |
|   |  |  |  | HOUR A.M. MONTH DAY YEAR  |  |  |  |  |  |  |  |
|   |  |  |  | P.M. 19   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED  |  |  |  | 21e. PLACE OF INJURY  |  | 21f. LOCATION  |  |  |  |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from NOV 10, 1986, 19 to NOV 15, 1986, that (I) (we) last saw the deceased alive on NOV 14, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  | DEGREE  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |
| JAMES M. BLAKE MD   |  |  |  |   |  |  |  |  |  | 11/17/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS  |  |  |  |  |  |  |  |
| JAMES M. BLAKE, MD  |  |  |  | 1222 171 DEFENSE HWY ANNAPOLIS 21411  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION  |  |  |  |  |  |
| Burial  |  | 11-18-86   |  | Lakemont Cemetery   |  | Davidsonville A.A. Md.   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| T.A. Hardesty Annapolis, Maryland 21401   |  |  |  |   |  | NOV 18 1986  |  | Julia Gordon-Randall   |  |  |  |

1101124

1101124

1101124

1101124

1101124

1101124

1101124

1101124

1101124

1101124

1101124

1101124

1101124

1101124

1101124

1101124



025043

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |  |  |  |  |  |
|---|--|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Bessie Davis   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov 21, 1986 |   |  | 2b. HOUR<br>1:33 P M   |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Black   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov 7, 1907   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel MD.                             |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Annapolis  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Anne Arundel Genl. Hospital |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE        |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |  |   | 13b. COUNTY<br>Anne Arundel   |  | 13c. CITY OR TOWN<br>DAVIDSONVILLE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>SAMUEL JOHNSON  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ELIZABETH WASHINGTON   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br>Annapolis, Md. 21403<br>MAUDE THOMAS 101 Roselawn Rd.  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) Coronary heart disease<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>immediate<br>1976 |  |  |   |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>Hypertension, Obstructive airway disease, cerebral infarct 10/2/86  |  |  |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 14 July 1976, to 21 Nov 1986, that (I) (we) last saw the deceased alive on 29 Oct 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.     |  |  |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Charles W. Kinzer   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br>21 Nov 1986  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Charles W. Kinzer  |  |  |   | 22e. ADDRESS<br>Annapolis, Maryland 21401   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>11-25-1986  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>PINELAWN MEM. PARK  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Annapolis A.A. Maryland                |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>WILLIAM REESE & SONS MORTUARY, P.A.   |  |  |   | 24. FUNERAL DIRECTOR<br>ADDRESS<br>Annapolis, Md. 21401   |  | 25a. DATE REC'D BY REGISTRAR<br>NOV 24 1986  |  |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use on the burial/transfer permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will have to be notified.





Case Four  
Home  
Bessie Davis

Union Memorial  
Cem.  
Davidsonville  
A. A. M.

263-3833

268-6015

Ree



24364

NOV 19 86

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 0 3 2 8

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |   |   |  |  |   |
|--|---|---|--|--|---|
| 1. DECEASED NAME<br>FIRST MIDDLE LAST<br>Polly Marie Dunn  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11/15/86  |  | 2b. HOUR<br>9:30 AM   |
| 3. SEX<br>Female   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 12, 1913  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.               | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel MD. |   |
| 10. CITY OR TOWN OF DEATH<br>Crofton   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Crofton Conv. Center |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home            |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD |   |   | 13b. COUNTY<br>A.A.  | 13c. CITY OR TOWN<br>Glen Burnie                         | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Fritts  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Nettie DuVall                               |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no                                       |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-14-2440  | 17. INFORMANT<br>29. ADDRESS<br>Park Traylor Village<br>William Fritts Millersville MD 21108 |  |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Left ventricular failure  
DUE TO, OR AS A CONSEQUENCE OF  
(b) Right renal cell carcinoma  
DUE TO, OR AS A CONSEQUENCE OF  
(c) Myocardial infarction

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

Minutes

Months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

|   |  |  |   |
|---|--|--|---|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/15/86</u> to <u>11/15/86</u> , that (I) (we) last saw the deceased alive on <u>11/15/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br><u>Max C. Frank MD</u>  | DEGREE<br>MD   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br>11/15/86  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MAX C FRANK MD   |  | 22e. ADDRESS<br>7575 Ritchie Hwy - Glen Burnie MD 21061  |   |

|   |                         |   |   |
|---|-------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                            | 23b. DATE<br>17 Nov. 86 | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem. Pk. | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie A.A. MD |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Kirkley Funeral Home Glen Burnie MD 21061 |                         | 25a. DATE REC'D. BY REGISTRAR<br>NOV 18 1986              | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Pandora              |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use on the burial/transit permit. Their please register this certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

MEDICAL CERTIFICATION

9

025172 NOV 25 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 0 3 2 9

REG. NO.

EST

|   |  |  |   |   |  |   |  |  |  |
|---|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HELEN Mary DULANEY</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 21, 1986</b>                |   |  | 2b. HOUR<br><b>1107 PM</b>  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 25 1921</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.   |  | 7. UNDER 1 YEAR IF UNDER 74 HRS.<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY</b> MD.                          |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |   |   |  |   |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Anne Arundel</b>   |   | 13c. CITY OR TOWN<br><b>Glen Burnie</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>926 Point Pleasant Rd. 21061</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Eugene Charles Zimmerman Sr</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Margaret Goski</b> |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>None</b>   |   | 17. INFORMANT (son)<br><b>Mr. Gilbert Dulaney Jr.</b>   |  | ADDRESS<br><b>907 Juliet Lane<br/>Arnold Md. 21012</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Advanced lung Cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.           |  |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 month</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a  |  |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-19</b> , 19 <b>86</b> , to <b>11-21</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>11-21</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  |  |   | DEGREE<br><b>M.D.</b>   |  |   |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HSU, LONG S M.D.</b>  |  |  |   | 22e. ADDRESS<br><b>500 HOSPITAL DRIVE SUITE 230<br/>GLEN BURNIE, MD 21061</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Nov. 25, 1986</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie Anne Arundel MD</b>                |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Singleton Funeral Home</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 25 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP \_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 show any injury, or other traumatic event, the medical examiner must be notified at once.

052133 11 22 22

WILLIAM H. BROWN

1. The first part of the report is a general description of the area. It is a large, flat, open area with a few scattered trees and shrubs. The ground is mostly bare and sandy. There are some small pools of water scattered throughout the area. The weather is clear and sunny. The temperature is in the 70s. The wind is light and from the west. The overall impression is of a dry, open landscape.

2. The second part of the report is a description of the vegetation. There are a few scattered trees and shrubs, mostly in the western part of the area. The trees are mostly small and young. The shrubs are mostly low and bushy. There are also some small, bare patches of ground. The overall impression is of a sparse, dry landscape.

3. The third part of the report is a description of the water resources. There are a few small pools of water scattered throughout the area. These pools are mostly in the western part of the area. The water in these pools is mostly clear and shallow. There are also some small, dry patches of ground. The overall impression is of a dry, open landscape.

4. The fourth part of the report is a description of the wildlife. There are a few small animals scattered throughout the area. These animals are mostly in the western part of the area. The animals are mostly small and young. The overall impression is of a dry, open landscape.



024014 NO

TO HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

99

BP \_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

| FOR<br>1 - STATE<br>REGISTRAR  |  |   |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  | 8 0 3 0 3 3 0                   |  |  |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
|--|--|---|--|--|--|--|--|--|--|--|--|---------------------------------|--|--|--|------------------|--|----------------------------|--|--------|--|--|--|-------|--|--|--|
|  |  |   |  |  |  | REG. NO.   |  |  |  |  |  |                                 |  |  |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  | MONTH                           |  | DAY  |  | YEAR             |  | 2b. HOUR                   |  |        |  |  |  |       |  |  |  |
| Jearline Felicitas Douglas   |  |   |  |  |  | Nov 8 1986   |  |  |  |  |  | A:                              |  | M  |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS                 |  |  |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
| F.   |  | B   |  | Mar 1 1921   |  | 65 YRS   |  |  |  | MONTHS   |  | DAYS                            |  | HOURS  |  | MIN.             |  |                            |  |        |  |  |  |       |  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |  |                                 |  |  |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
| Md   |  | U.S.A.  |  |  |  |  |  |  |  | A.A. MD  |  |                                 |  |  |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  |                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
| Annapolis  |  | 1125 Madison St   |  |  |  |  |  |  |  | Stenographer   |  |                                 |  |  |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  | 13e. STREET ADDRESS / ZIP CODE                                   |  |                                 |  |  |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
| Md   |  | A.A.  |  | Annapolis  |  |  |  |  |  | 1125 Madison St Apt 2 21403                                      |  |                                 |  |  |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
| 14. FATHER'S NAME  |  |   |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |                                 |  |  |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
| Charles T. Hen   |  |   |  |  |  | Florence Colbert   |  |  |  |  |  |                                 |  |  |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  | 17. INFORMANT ADDRESS  |  |                                 |  |  |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
| No   |  |   |  |  |  | 215 18 0418  |  |  |  | Thomas Henry 8700 Normal School Rd                               |  |                                 |  |  |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
| IMMEDIATE CAUSE (a) Myocardial infarction  |  |   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
| (b) Hypertension   |  |   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
| (c) Arteriosclerosis Cordis et Cerebri   |  |   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  |  |  |  | 20a. AUTOPSY?  |  |                                 |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
|  |  |   |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |                                 |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |  |                                 |  |  |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
|  |  |   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  |  | 21f. LOCATION<br>STREET  |  |  |  | CITY OR TOWN                    |  |  |  | COUNTY           |  |                            |  | STATE  |  |  |  |       |  |  |  |
|  |  |   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from February 19 83 to Nov 6 19 86, that (I) (we) saw the deceased alive on Oct 22 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
| 22b. SIGNATURE   |  |   |  |  |  |  |  |  |  |  |  | DEGREE                          |  |  |  | 22c. DATE SIGNED |  |                            |  |        |  |  |  |       |  |  |  |
| Donald C. Roane, M.D.  |  |   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS                    |  |  |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
| Donald C. Roane  |  |   |  |  |  |  |  |  |  |  |  | 1616 Forest Drive Annapolis, Md |  |  |  |                  |  |                            |  |        |  |  |  |       |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |   |  | 23b. DATE  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  | 23d. LOCATION                   |  |  |  | CITY OR TOWN     |  |                            |  | COUNTY |  |  |  | STATE |  |  |  |
| Burial   |  |   |  | Nov 13, 1986   |  |  |  | St. Mary Catholic  |  |  |  | Annapolis                       |  |  |  | A.A. Md          |  |                            |  |        |  |  |  |       |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |   |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  |  |  |                  |  | 25b. REGISTRAR'S SIGNATURE |  |        |  |  |  |       |  |  |  |
| C.E. Hicks, III 1922 Forest Drive Anna, Md   |  |   |  |  |  |  |  |  |  |  |  | NOV 13 1986                     |  |  |  |                  |  | Julia Gordon-Randall       |  |        |  |  |  |       |  |  |  |

02401010450

... ..

...

...

...

...

...

...

...

...

...

...

...

...

...

...

1

...

...

...

...

...

...

24371.NOV 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8630331

|  |  |   |  |   |
|--|--|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Marie (NMN) Donehoo  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR HOUR<br>November 13, 1986 11:20 PM                                   |   |
| 3. SEX<br>Female   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 2, 1901   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Washington, DC  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel Co. MD.   |   |
| 10. CITY OR TOWN OF DEATH<br>Millersville  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN STATE CITY, GIVE STREET ADDRESS)<br>Knollwood Manor Nursing Home |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                            | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  | 13b. COUNTY<br>A A Co.  | 13c. CITY OR TOWN<br>Pasadena  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Thomas E. Waggaman   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Christine Waggaman   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>NA  | 17. INFORMANT (Daughter) ADDRESS<br>Eleanor D. Balze 115 Crest Ave.<br>Glen Burnie, Md. 21061            |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Septic failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Meningitis to liver</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cholera</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Tuberculosis</u>  |  |   |  |   |
| 19a. DATE OF OPERATION<br>9/9/86   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/23</u> 19 <u>86</u> , to <u>11/13</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>10/26</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                       |  |   |  |   |
| 22b. SIGNATURE<br><u>E. A. Chell</u>   |  | 22c. DATE SIGNED<br>11/14/86  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BROOK A Chell  |
| 22e. ADDRESS<br>1835 Forest Drive, Baltimore   |  | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>             |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  | 23b. DATE<br>Nov 14, 1986  | 23c. NAME OF CEMETERY OR CREMATORY<br>Security Process, Inc.  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville Balto. Md.                                     | 25a. DATE REC'D. BY REGISTRAR<br>NOV 18 1986  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Singleton Funeral Home   |  | 25b. REGISTRAR'S SIGNATURE<br>Glen Burnie, Maryland   |  |   |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified of cause.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove accompanying card 1 and it should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the health department within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |   |   |  |  |  |
|---|--|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Dorothy Edith Dixon</b>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 23, 1986</b> |   |  | 2b. HOUR<br>M<br><b>M</b>  |  |
| 3. SEX<br><b>female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>August 23 1900</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington DC</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>       |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel Co.</b> MD.                             |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Anne Arundel General Hosp.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>American Forestry Asso</b>   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>AACo.</b>  |  | 13c. CITY OR TOWN<br><b>Annapolis</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>Rt. 1 1742 Ramshore Trail 21401</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Davis</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Blanche Garrol</b>  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII 579-44-3285</b>  |   | 17. INFORMANT ADDRESS<br><b>Dorothy E. Lingeback Same as #13</b>                                |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>NEPHROTIC SYNDROME, ACUTE RENAL FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>3 m.</b> |  |  |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 m. 10 s.</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)  |  |  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>86</b> , to <b>11-23</b> , 19 <b>86</b> , that (I) (we) lost<br>saw the deceased alive on <b>11-23</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                |  |  |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>John D. Jackson</b>  |  |  |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   |  | 22c. DATE SIGNED<br><b>11-24-86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN D. JACKSON</b>   |  |  |  | 22e. ADDRESS<br><b>1533 FOREST DR, ANNAPOLIS, MD 21401</b>  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11-25-86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lakemont Cemetery</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Davidsonville AACo Md.</b>                     |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hardesty Funeral Home Annapolis,</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 26 1986</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Gordon-Randall</b>                                       |  |  |  |

BP

Casey, Calif. 1900



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 96 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |                  |  |  |   |   |   |  |  |
|--|------------------|--|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Edward Arthur Diedrich  |                  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>11 24 1986                 |   |   | 2b. HOUR<br>M   |  |  |
| 3. SEX<br>Male   | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 14, 1914   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>72 YRS.                      | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.  | 2c. DATE PRONOUNCED DEAD<br>11 24 1986  | 2d. HOUR<br>1:50P<br>M                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel County, MD                     |  |  |
| 10. CITY OR TOWN OF DEATH<br>Annapolis   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sandy Point Marina (parking lot) |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Machinist                      |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Factory |  |
| 13a. STATE<br>Md.  |                  |  | 13b. COUNTY<br>A.A.  | 13c. CITY OR TOWN<br>Severna Park   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>713 Dividing Rd. / 21146                                     |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edward H. Diedrich   |                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Emma Howard Smith |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-----   |  | 17. INFORMANT<br>ADDRESS<br>Mr. Edward R. Diedrich (same as 13)   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Shotgun wound of abdomen</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                           |                  |  |  |   |   |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                  |  |  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  | 21b. TIME OF INJURY<br>HOURS MONTH DAY YEAR<br>12:40 11 24 1986  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br>Self inflicted   |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>parking lot   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Sandy Point Marina A.A. Co, MD.  |   |   |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |  |  |   |   |   |  |  |
| ACTUAL SIGNATURE<br><i>William M. Zane</i>   |                  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER   |  |   |   | DATE SIGNED 11/25/86  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>William M. Zane, M.D.  |                  | ADDRESS 111 Penn St. Balto.MD.   |  |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |                  | 23b. DATE<br>11-26-1986  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Crematory  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Westview Balt. Co. Md.                |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>BARRANCO F.H. SEVERNA PARK, Md. 21146  |                  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 28 1986  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Anderson-Randolph</i>                        |  |  |

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))





RECEIVED 1911  
JAN 10 1911

023580 NOV 1986

item #2a, Film G621, 11/13/86 rja

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 0 3 3 4

REG. NO.

|   |                         |  |  |   |                              |
|---|-------------------------|--|--|---|------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARY K. Dietrich</b>   |                         |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>11-6-86</b> |   | 2b. HOUR<br><b>1:40 P.M.</b> |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>11 1 92</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>94 yrs.</b>   |                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore MD</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |                              |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL Co. MD.</b>   |                         | 10. CITY OR TOWN OF DEATH<br><b>SEVERNAPARK MD</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERIDIAN SEVERNAPARK</b>  |                              |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |                         | 12b. KIND OF BUSINESS OR INDUSTRY  |  | 13a. STREET ADDRESS / ZIP CODE<br><b>Balto. Md. 21230</b>   |                              |
| 13a. STATE<br><b>MD.</b>  |                         | 13b. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ADOLF ----- Schaedler</b>  |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Katherine Shakowski</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |                              |
| 16b. SOCIAL SECURITY NO.<br><b>213-74-0070</b>  |                         | 17. INFORMANT<br>NAME ADDRESS<br><b>Carmelinda Sanchez Meridian Way Co Spark</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Pulmonary Arrest.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Atherosclerotic Cardiovascular Disease.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes mellitus type II.</b> |                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) |                         |  |  |   |                              |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                              |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |                         | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |                              |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                         | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                              |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                         | 22a. I certify that (I) (this hospital) attended the deceased from <b>Aug. 15</b> , 19 <b>86</b> , to <b>November 6</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>Nov 3</b> , 19 <b>86</b> , and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><b>Alan N. Dennis M.D.</b>  |                              |
| 22c. DATE SIGNED<br><b>11/6/86</b>  |                         | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Alan N. Dennis</b>   |  | 22e. ADDRESS<br><b>3001 S. Hanover St Balto MD.</b>   |                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |                         | 23b. DATE<br><b>11/8/1986</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross Cent.</b>   |                              |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. A.A.Co. Maryland</b>  |                         | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Balto. Md. 21230<br/>McCully Funeral Home, 130 E. Fort Ave.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 10 1986</b>   |                              |
| 25b. REGISTRAR'S SIGNATURE  |                         |  |  |   |                              |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon 3 and 4 and 2 should be filed with 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Mather  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOV - 19 - 86   |  |  | 2b. HOUR<br>4 <sup>10</sup> P.M.   |  |  |
| 3. SEX<br>Male   |  |  | 4. RACE<br>Caucasian   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>01 - 20 - 01                                   |  |  |
| 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br>85   |  |  | 7. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Ohio  |  |  | 8. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel County MD.                      |  |  |
| 9. CITY OR TOWN OF DEATH<br>Annapolis  |  |  | 10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Annapolis Convalescent Center |  |  | 11. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Electrician       |  |  |
| 12. USUAL RESIDENCE<br>(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>12a. STATE<br>Maryland   |  |  | 12b. COUNTY<br>Anne Arundel  |  |  | 12c. CITY OR TOWN<br>Arnold  |  |  |
| 13. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Dclan  |  |  | 14. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Hall   |  |  | 15. STREET ADDRESS / ZIP CODE<br>602 Southern Hills Dr./21012                        |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>1919 - 1922   |  |  | 17. INFORMANT<br>ADDRESS<br>Phyllis Dolan (Same as # 13)                             |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebrovascular Accident</u><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2-24<br>?  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/18/86 to 11/19/86, that (I) (we) last saw the deceased alive on 11/18/86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (If we (I) did (did not) view the body after death, so state).   |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Richard Coleman  |  |  | DEGREE<br>M.D.   |  |  | 22c. DATE SIGNED<br>11/19/86   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RICHARD COLEMAN   |  |  | 22e. ADDRESS<br>702 Giddings Ave. / Baltimore, MD  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  |  | 23b. DATE<br>11-20-86  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Crematory                             |  |  |
| 23d. LOCATION<br>(CITY OR TOWN)<br>Westview, Baltimore   |  |  | 23e. COUNTY<br>Anne Arundel  |  |  | 23f. STATE<br>MD.  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>BARRANCO FUNERAL HOME  |  |  | 24b. ADDRESS<br>495 RITCHIE HWY 21146<br>Severna Park MD   |  |  | 25. DATE REC'D. BY REGISTRAR<br>NOV 20 1986  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove this portion of the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

USA 100% COTTON

30% COTTON FIBER

MADE IN USA

MADE IN USA



024963 NOV 25 1986

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |  |   |   |
|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Doris E. Edwards   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 18, 1986   |   | 2b. HOUR<br>M   |
| 3. SEX<br>Female  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>November 21, 1927  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>58<br>YRS.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore, MD  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel County MD                                  |
| 10. CITY OR TOWN OF DEATH<br>Glen Burnie  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>North Arundel Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br>Maryland  |   | 13b. COUNTY<br>Baltimore   | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Oliver H. Wroten  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anne E.   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN)<br>No   |   | 16b. SOCIAL SECURITY NO.<br>216-20-1312  |   | 17. INFORMANT<br>ADDRESS<br>William Henry Edwards, Same as 13                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Advanced Lung Cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>_____ |   |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |   |  |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)                  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-18</u> , 19 <u>85</u> , to <u>11-18</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>11-18</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |  |   |   |
| 22b. SIGNATURE<br><u>Long S. Hsu</u>  |   | DEGREE<br>M.D.<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>11-19-86  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Long S. Hsu, M.D.  |   | 22e. ADDRESS<br>300 Hospital Drive, Suite 230, Glen Burnie, MD   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   | 23b. DATE<br>Nov. 19, 86  | 23c. NAME OF CEMETERY OR CREMATORY<br>Security Process, Inc.   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville Baltimore MD        |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>James S. Kirkley, Glen Burnie, MD   |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 21 1986   |   | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson-Kendall</u>                                      |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(REPORT ANT. If item 21 is marked on item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.)





024298 NOV 18 86

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 4. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition of the body.

IMPORTANT: If item 2 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |  |  |  |   | REG. NO.  |  |
|--|--|---|--|---|---|--|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILLIAM K. EUSTICE</b>  |  |   |  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-06-86</b>   |  |  | 2b. HOUR<br><b>0523</b> <sup>M</sup>  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 22 16</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Ohio</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel County</b> MD.   |  |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Fort Meade</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Kimbrough Army Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Military</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>US Government</b>   |   |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>PG</b>  |  | 13c. CITY OR TOWN<br><b>Bowie</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>12703 Kingsfield Lane</b> <b>20715</b>        |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William K. Eustice, Sr.</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ellen Johnston</b>  |   |  |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>career</b>  |  | 17. INFORMANT<br><b>Helene M. Piper</b>   |   |  | ADDRESS<br><b>same as 13e.</b>   |  |   |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory/cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>COPD Aspiration</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Peripheral Vascular Disease</b>   |  |   |  |   |   |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |   |  |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21i. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-6</b> , 19 <b>86</b> , to <b>11-6</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>11-6</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |  |  |  |   |   |  |
| 22b. SIGNATURE<br><b>Paul T. McBride, MD</b>   |  |   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>11-6-86</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>McBRIDE, PAUL T.</b>   |  |   |  |   |   | 22e. ADDRESS<br><b>Kimbrough Army Hospital, Ft. Meade, Maryland</b>  |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal/Burial</b>  |  |   | 23b. DATE<br><b>NOV 12, 1986</b>                                       |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary Cemetery</b> |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Shawnee, Pattawomie, Oklahoma</b> |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Beall Funeral Home</b> ADDRESS <b>16000 Annapolis Road Bowie, MD 20715-3043</b>  |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1986</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Anderson-Parker</b>  |   |  |



026001 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 3 0 3 3 8

REG. NO.

FOR  
STATE  
REGISTRAR

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Angeline S. Ferreira</i>                         |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>Nov. 27, 1986</i>                           |  | 2b. HOUR<br><i>P.M.</i>  |
| 3. SEX<br><i>Female</i>   | 4. RACE<br><i>White</i>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Feb. 3, 1892</i>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>88</i> YRS.                  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>BERMUDA</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Anne Arundel</i> MD.    |  |
| 10. CITY OR TOWN OF DEATH<br><i>Annapolis</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Annapolis Convalescent Center</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Governess.</i> | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Retired</i>                |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><i>Md. A.A.</i> |   |   | 13b. CITY OR TOWN<br><i>Annapolis</i>   | 13c. STREET ADDRESS / ZIP CODE<br><i>5 Silverwood Circle 21403</i> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Francisco Ferreira</i>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Guilhelmina Correia</i>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>                               | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>827-28-1436</i>   | 17. INFORMANT<br>ADDRESS<br><i>William T. Devine, Jr.</i>   |   | <i>Same as #13</i>   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*Arteriosclerotic cerebrovascular disease*

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *None*

MEDICAL CERTIFICATION

|   |  |  |  |
|---|--|--|--|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10/85</i> to <i>11/27</i> 19 <i>86</i> , that (I) (we) lost sight of the deceased alive on <i>10/86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><i>Gregory Mitchell</i>   | 22c. DATE SIGNED<br><i>11/29/86</i>                                    |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Gregory Mitchell</i>  | 22e. ADDRESS<br><i>205 Ridgely Ave Annapolis, Md.</i>                  |  |  |

|  |                             |  |   |
|--|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br><i>Burial</i>                                   | 23b. DATE<br><i>12-1-86</i> | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Hillcrest</i> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Annapolis A.A. Md.</i> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Taylor Funeral Chapel Annapolis Md.</i> |                             | 25a. DATE REC'D. BY REGISTRAR<br><i>DEC 3 1986</i>     | 25b. REGISTRAR'S SIGNATURE<br><i>John S. Smith</i>                      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "other," show any injury, or other traumatic event, or medical condition that must be certified.

1

025721 DEC 3 1986

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30339

FOR  
STATE  
REGISTRAR

|  |                       |  |   |   |                         |
|--|-----------------------|--|---|---|-------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>John Franklin Fochtman</b>                      |                       |  | 2a. DATE KNOWN OF DEATH<br>EST. <b>11 22 86</b>   |   | 2b. HOUR<br><b>0341</b> |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>CAU</b> | 5. DATE OF BIRTH<br>MONTH <b>11</b> DAY <b>08</b> YEAR <b>32</b>                           | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>54</b> YRS. | 7c. DATE PRONOUNCED DEAD<br>MONTH <b>11</b> DAY <b>22</b> YEAR <b>86</b>  | 7d. HOUR<br><b>0341</b> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Duluth, MN</b>                         |                       | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                         |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>AA</b>                                      |                       | 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>  |   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Anne Arundel Gen</b>                       |                         |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Consultant</b>     |                       | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Legislative</b>                                    |   | 13a. STREET ADDRESS<br><b>8A3 President Point</b>   |                         |
| 13b. STATE<br><b>MD</b>  |                       | 13c. CITY OR TOWN<br><b>Annapolis</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                         |
| 14. FATHER'S NAME<br>FIRST <b>E. Frank</b> MIDDLE <b>Fochtman</b> LAST <b>Fochtman</b> |                       | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Catherine</b> MIDDLE <b>Fisher</b> LAST <b>Fisher</b> |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>yes</b>  |                         |
| 16b. SOCIAL SECURITY NO.<br><b>1952-1956</b>   |                       | 16c. SOCIAL SECURITY NO.<br><b>468-34-6893</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Jed Fochtman, 2717 Franklin Ct., Alex, VA</b>  |                         |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chest &amp; Head TRAUMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Motor Vehicle Accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

|  |  |  |  |   |
|--|--|--|--|---|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                              |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                       |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>0230 P.M. 11-22 1986</b> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>Head on collision</b> |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Street</b>   |  | 21f. LOCATION<br>STREET <b>Muddy Creek Rd</b> CITY OR TOWN <b>AA</b> COUNTY <b>MD</b> STATE <b>MD</b>     |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |   |
| ACTUAL SIGNATURE<br><b>William P. J...</b>   |  | TITLE (SPECIFY)<br><b>Deputy</b>   |  | DATE SIGNED<br><b>11-22-86</b>  |
| EXAMINER'S NAME (TYPE OR PRINT) ADDRESS  |  |  |  |   |

|  |  |                              |  |  |
|--|--|------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial, Removal</b>       |  | 23b. DATE<br><b>11/25/86</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Quantico National</b> | 23d. LOCATION<br>CITY OR TOWN <b>Quantico, Virginia</b> COUNTY <b>AA</b> STATE <b>MD</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Green Funeral Home, Herndon, Virginia</b> |  |                              | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 1 1986</b>             | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Dindon-Randall</b>                                |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30540

|  |  |                       |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |       |  |
|--|--|-----------------------|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-------|--|
| 1. FOR STATE REGISTRAR   |  |                       |  |   |  |  |  |  |  | 7a. DATE KNOWN OF DEATH  |  | MONTH DAY YEAR   |  | 7b. HOUR   |  |  |  |  |  |       |  |
| 2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>William Chesley Gandy Jr.</b>   |  |                       |  |   |  |  |  |  |  | ESTIMATED <input checked="" type="checkbox"/> MATED <input type="checkbox"/> |  | 11 11 86   |  | M  |  |  |  |  |  |       |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>Can</b> |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>7 16 42</b>   |  | 6. AGE IN YEARS (LAST BIRTHDAY)<br><b>44 YRS.</b>                |  | IF UNDER 1 YR. MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br><b>11 11 86</b>                       |  | 7d. HOUR<br><b>2025</b>                                |  |  |  |  |  |       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Florida</b>  |  |                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>AA</b>                                |  |  |  |  |  |  |  |       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Colen Burnie</b>   |  |                       |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>North Arundel</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Truck Driver</b>   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>                         |  |  |  |  |  |  |  |       |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                       |  |   |  |  |  |  |  | 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Anne Arundel</b>   |  | 13c. CITY OR TOWN<br><b>Balto</b>                      |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>422 Cresswell Road</b> |  | 21225 |  |
| FATHER'S NAME FIRST MIDDLE LAST<br><b>William Chesley Gandy Sr</b>   |  |                       |  |   |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Gladys M. Meggs</b>         |  |  |  |  |  |  |  |  |  |       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>No</b>  |  |                       |  | 16b. SOCIAL SECURITY NO.<br><b>220-38-5145</b>  |  |  |  | 17. INFORMANT<br><b>Albert T. Owen</b>   |  |  |  | ADDRESS<br><b>Same as 13e</b>  |  |  |  |  |  |  |  |       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Fracture C-1 Spine</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Multiple Trauma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                    |  |                       |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |                       |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |       |  |
| 19a. DATE OF OPERATION   |  |                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |       |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><b>11:30 P.M. 11/12/86</b>   |  |                       |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>11:30 P.M. 11/12/86</b>  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Hit by Auto</b>  |  |  |  |  |  |  |  |  |  |  |  |       |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                       |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Street</b>  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>Rte 2 &amp; Jumpers Hale AA Md.</b>   |  |  |  |  |  |  |  |  |  |  |  |       |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                       |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |       |  |
| ACTUAL SIGNATURE<br><b>William P. Jones</b>  |  |                       |  | TITLE (SPECIFY)<br><b>M.D. Deputy</b>   |  |  |  | MEDICAL EXAMINER   |  |  |  | DATE SIGNED<br><b>11/12/86</b>   |  |  |  |  |  |  |  |       |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>William P. Jones, M.D.</b>   |  |                       |  | ADDRESS<br><b>695 America Crt. Davidsonville, Md. 21035</b>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |                       |  | 23b. DATE<br><b>11/14/86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b> |  |  |  | 23d. LOCATION CITY COUNTY STATE<br><b>Baltimore A.A. Md</b>                  |  |  |  |  |  |  |  |  |  |       |  |
| 24. FUNERAL DIRECTOR<br><b>George J. Gonce 4001 Ritchie Hwy Balto Md</b>   |  |                       |  |   |  |  |  |  |  | 25a. DATE REC'D BY REGISTRAR<br><b>NOV 13 1986</b>                           |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia D. R. R. R.</b> |  |  |  |  |  |       |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

MEDICAL CERTIFICATION



02880 21103

Mr. Jones  
1000 1000 1000  
1000 1000 1000  
1000 1000 1000

1000 1000 1000  
1000 1000 1000  
1000 1000 1000  
1000 1000 1000

1000 1000 1000  
1000 1000 1000  
1000 1000 1000  
1000 1000 1000

1000 1000 1000  
1000 1000 1000  
1000 1000 1000  
1000 1000 1000

1000 1000 1000  
1000 1000 1000  
1000 1000 1000  
1000 1000 1000

1000 1000 1000  
1000 1000 1000  
1000 1000 1000  
1000 1000 1000

026207 DEC 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the file. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   | REG. NO. 86 30341 |  | EST |  |
|--|--|--|--|---|-------------------|--|-----|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>EMIL T GASSMANN</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 30, 1986</b>   |                   | 2b. HOUR<br><b>430 AM</b>  |     |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1-22-1909</b>  |                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b><br>YRS. MONTHS DAYS   |     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>   |     |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Minister</b>   |                   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Church</b>   |     |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |  |  | 13b. COUNTY<br><b>A.A.</b>  |                   | 13c. CITY OR TOWN<br><b>Pasadena</b>   |     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles G. Gassmann</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sadie Goodwin</b>   |                   |  |     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213010130A</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Audrey Gassmann (SAME AS ABOVE)</b>  |                   |  |     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Small bowel obstruction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Gall bladder Cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 month</b><br><b>2 months</b> |  |  |  |   |                   |  |     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |                   |  |     |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                   |  |     |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                   |  |     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-31</b> , 19 <b>86</b> , to <b>11-30</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>11-30</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |                   |  |     |  |
| 22b. SIGNATURE<br><b>Long S. Iseu M.D.</b>   |  |  |  | 22c. DEGREE<br><b>MD.</b>   |                   | 22d. DATE SIGNED<br><b>11-30-86</b>  |     |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LONG S. ISEU, M.D.</b>   |  |  |  | 22f. ADDRESS<br><b>300 HOSPITAL DRIVE SUITE 230 GLEN BURNIE, MD 21061</b>   |                   |  |     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Buried</b>   |  | 23b. DATE<br><b>12-3-86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven</b>   |                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie A.A. MD</b>   |     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>ROBERT S. BARRANCO</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 4 1986</b>  |                   |  |     |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Severna Park, MD. 21146</b>   |  |  |  | 25c. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |                   |  |     |  |

026701 00-01

EST

NOVEMBER 20, 1954 1:30 PM

WILLIAM J. DUNN

WILLIAM J. DUNN

WILLIAM J. DUNN

11-20-54

11-20-54

11-20-54

11-20-54

11-20-54

11-20-54

100 HOSPITAL DRIVE SUITE 230

NEW YORK, N.Y. 10001

NEW YORK, N.Y. 10001

024542 NOV 20 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must complete page 4.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 0 3 4 2  
REG. NO. EST

|  |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILLIAM J. GESSER</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 17, 1986</b> |   |  | 2b. HOUR P M<br><b>2:30 P</b>   |  |   |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>6 19 19</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>67 YRS.</b>                |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>                  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Warrant officer</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Coast Grd.</b>  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>A.A.</b>  |  | 13c. CITY OR TOWN<br><b>Pasadena</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | 13e. STREET ADDRESS / ZIP CODE<br><b>108 Appian Way 21122</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Edward A. Gesser</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Lily C. Boss</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>yes</b>  |  |   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>9/37-1/70</b>  |  | 17. INFORMANT ADDRESS<br><b>Betty Jane Gesser (same as 13E)</b>                         |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>CEREBROVASCULAR DISEASE.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |   |  |   |  |
|  |  |   |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-15, 1986</b> , to <b>11-17, 1986</b> , that (I) (we) lost saw the deceased alive on <b>11-17-1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.    |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE <b>Harshad R. Mody</b>  |  |   |  | DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED <b>11-19-86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HARSHAD R. MODY, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>14 WELLHAM AVENUE #103 GLEN BURNIE, MARYLAND 21061</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>burial</b>   |  | 23b. DATE<br><b>11/20/86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Vet/Crownsville</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Crownsville A.A. Md.</b>                  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>George Gonce</b>  |  |   |  | 4001 Ritchie Hwy Baltimore Md. 21225  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1986</b>                                     |  | 25b. REGISTRAR'S SIGNATURE<br><b>Lita Anderson-Randall</b>  |  |

054243 12/2/50

20% COTTON FIBER  
DOWN

NOV 1 1950

025720 DEC-86

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 0 3 4 3

REG. NO.

|   |  |  |  |   |  |   |  |  |  |   |  |
|---|--|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>George</u>   |  | FIRST <u>B.</u>  |  | MIDDLE <u>Gifford</u>   |  | LAST  |  | 2a. DATE OF DEATH<br>MONTH <u>11</u> DAY <u>24</u> YEAR <u>86</u>  |  | 2b. HOUR<br><u>5:00 P.M.</u>                  |  |
| 3. SEX<br><u>Male</u>   |  | 4. RACE<br><u>White</u>  |  | 5. DATE OF BIRTH<br>MONTH <u>2</u> DAY <u>26</u> YEAR <u>1920</u>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>66</u> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <u></u> DAYS <u></u>   |  | IF UNDER 24 HRS<br>HOURS <u></u> MIN. <u></u> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Minnesota</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Anne Arundel county</u> MD.                          |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><u>Annapolis</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Anne Arundel General Hospital</u>  |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Attorney</u>             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>private</u>  |  |   |  |
| 13a. STATE<br><u>MD.</u>  |  | 13b. COUNTY<br><u>XX XXXXX</u>   |  | 13c. CITY OR TOWN<br><u>Upper Marlboro</u>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><u>14600 Mt Calvert Rd, 20772</u>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST <u>George</u> MIDDLE <u>B.</u> LAST <u>Gifford</u>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>Lillian</u> MIDDLE <u></u> LAST <u>Nightlinger</u>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <u>yes</u>   |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF NOT GIVING WAR OR DATES) <u>WW 11</u>  |  | 17. INFORMANT<br><u>Barbara Gifford</u>       |  |
| 16c. ADDRESS<br><u>same as 13e</u>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u></u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u></u>  |  |  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u></u> P.M. <u>19</u>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)  |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/22</u> 19 <u>86</u> to <u>11/24</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>11/24</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>H.D. GOLDSTEIN, M.D.</u>  |  |  |  | 22c. ADDRESS<br><u></u>   |  |   |  | 22e. DATE SIGNED   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>cremation</u>   |  | 23b. DATE<br><u>11/25/86</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Metropolitan</u>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Alexandria Fairfax Virginia</u>                |  | 25a. DATE REC'D. BY REGISTRAR<br><u>DEC 1 1986</u>   |  |   |  |
| 24. FUNERAL DIRECTOR<br><u>Donald V. Borgwardt</u>  |  | 4400 Powder Mill Rd<br>Beltsville, Md. 20705   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Swiden-Randall</u>   |  |   |  |  |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return certificate to pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified at once.

BP

058150 DEC-308



RECEIVED  
FEB 1 1961  
U.S. AIR FORCE  
HEADQUARTERS  
AFMPC  
WRIGHT-PATTERSON AFB  
OHIO



024817 NOV 24 1986

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 - 3 0 3 4 4  
REG. NO. EST

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARGARET Cook GILL</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 16, 1986</b>                                     |   | 2b. HOUR<br><b>0248 AM</b>   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 1, 1903</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Teacher - Baltimore City</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>City</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>E. Everett Cook</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ella Nora LeCompte</b>                          |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214-22-8391</b>  |   | 17. INFORMANT ADDRESS<br><b>MD 21146</b><br><b>Mary Curry, 523 White Oak Dr., Severna Park,</b>           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                    |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>2 days</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-14</b> , 19 <b>86</b> , to <b>11-16</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>11-15</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) (did not) view the body after death. |  |   |   |   |  |
| 22b. SIGNATURE<br><b>LONG S. HSU</b><br>DEGREE <b>M.D.</b>  |  |   |   | 22c. DATE SIGNED<br><b>11-16-86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LONG S. HSU</b>   |  |   |   | 22e. ADDRESS<br><b>300 HOSPITAL DRIVE SUITE 230<br/>GLEN BURNIE, MARYLAND 21061</b>                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   | 23b. DATE<br><b>11-17-86</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Security Process, Inc.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Catonsville Balt. MD</b>                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Tom Helfenbein Funeral Home, Chester, MD 21619</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 21 1986</b><br>25b. REGISTRAR'S SIGNATURE<br><i>Guia J. J. J.</i> |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.



025317 NOV 25

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 0 3 4 5

REG. NO.

|   |   |  |   |  |                                     |  |                                     |                               |
|---|---|--|---|--|-------------------------------------|--|-------------------------------------|-------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | FIRST  | MIDDLE  | LAST   | 2a. DATE OF DEATH<br>MONTH DAY YEAR |  | 2b. HOUR<br>M                       |                               |
| Vincent L. Glorioso   |   |  |   |  | Nov. 21, 1986                       |  |                                     |                               |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH<br>MONTH DAY YEAR   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS   |                                     | IF UNDER 1 YEAR<br>MONTHS DAYS   |                                     | IF UNDER 24 HRS<br>HOURS MIN. |
| Male  | White   | Dec. 6, 1929   |   | 56   |                                     |  |                                     |                               |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>A.A.Co.Md. MD.                               |                                     |  |                                     |                               |
| Maryland  | U S A   |  |   |  |                                     |  |                                     |                               |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                                     |                               |
| Pasadena  | 8081 Round Table Ct. Pasadena   |  | Attorney  |  | Pasadena, Md. 21122                 |  |                                     |                               |
| 13a. USUAL RESIDENCE<br>(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   | 13b. COUNTY   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE   |                                     |  |                                     |                               |
| Maryland  | A.A.Co.   | Pasadena   |   | 8081 Round Table Ct. 21122   |                                     |  |                                     |                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |   |  |                                     |  |                                     |                               |
| Vincent L. Glorioso   |   | Mildred P. Gatton  |   |  |                                     |  |                                     |                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS  |                                     |  |                                     |                               |
| Yes   |   | Korean   |   | Mrs. Patricia J. Glorioso, Same as above   |                                     |  |                                     |                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |  |                                     |  |                                     |                               |
| IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>  |   |  |   |  |                                     |  |                                     |                               |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Lung metastases</u>   |   |  |   |  |                                     |  |                                     |                               |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |   | DUE TO, OR AS A CONSEQUENCE OF (c) <u>Colorectal Cancer</u>  |   |  |                                     |  |                                     |                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:  |   |  |   |  |                                     |  |                                     |                               |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                     |                               |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |                                     |  |                                     |                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                     |  |                                     |                               |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/12</u> , 19 <u>86</u> , to <u>11/21</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>11/8</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not (did) (did not) see the body after death. |   | 22b. SIGNATURE<br><u>[Signature]</u><br>DEGREE <u>MD</u><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  |                                     |  | 22c. DATE SIGNED<br><u>11/24/86</u> |                               |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |   | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |                                     |                               |
| Cremation   |   | 11/24/86   |   | Security Process Crem.   |                                     | Catonsville, Balto. Co. Md.  |                                     |                               |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |   |  |   | 25a. DATE REC'D. BY REGISTRAR  |                                     | 25b. REGISTRAR'S SIGNATURE   |                                     |                               |
| McCully Funeral Home, 3204 Mt. Rd. Pasadena, Md. 21122  |   |  |   | NOV 25 1986  |                                     | <u>[Signature]</u>   |                                     |                               |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send this certificate, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic condition, the medical examiner must be notified at once.

BP

022311 110250

RECEIVED  
OFFICE OF THE  
DIRECTOR

RECEIVED  
OFFICE OF THE  
DIRECTOR

RECEIVED  
OFFICE OF THE  
DIRECTOR

RECEIVED  
OFFICE OF THE  
DIRECTOR

RECEIVED  
OFFICE OF THE  
DIRECTOR

RECEIVED  
OFFICE OF THE  
DIRECTOR

RECEIVED  
OFFICE OF THE  
DIRECTOR



025373

NOV 29

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

30340

REG. NO.

FOR  
1. STATE  
REGISTRAR

|  |   |   |  |  |                              |
|--|---|---|--|--|------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Mildred Everett Gorman  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 23 86  |  | 2b. HOUR<br>12:55 PM         |
| 3. SEX<br>Female   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>07 12 92  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>94 YRS  |                              |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Iowa   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>AA Co. MD.   |                              |
| 10. CITY OR TOWN OF DEATH<br>Crownsville   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Fairfield Anndel Nurs Home |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |                              |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |   |  |  |                              |
| 13a. STATE<br>Maryland   | 13b. COUNTY<br>A.A. Co.   | 13c. CITY OR TOWN<br>Annapolis  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 13e. STREET ADDRESS / ZIP CODE<br>217 Norwood Road 21401   |                              |
| FATHER'S NAME<br>FIRST MIDDLE LAST<br>Clarence Bacon Everett   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Achsa French   |  |  |                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>—  | 17. INFORMANT<br>John R. Gorman-<br>ADDRESS Same as #13   |  |  |                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CHF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Congestive Heart Failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   |   |  |  |                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0  |   |   |  |  |                              |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                              |
| 22a. I certify that (1) (this hospital) attended the deceased from Feb 85 to Nov 23 1986, that (1) we last saw the deceased alive on Nov. 21 1986, and that in (my) our opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.       |   |   |  |  |                              |
| 22b. SIGNATURE<br>AC   |   | DEGREE  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>11-24-86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Anthony Caputo  |   | 22e. ADDRESS<br>132 Holiday Court Annapolis MD 21401  |  |  |                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  | 23b. DATE<br>Nov. 24, 1986  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland PG MD   |                              |
| 24. FUNERAL DIRECTOR<br>NAME<br>Taylor Funeral Chapel Annapolis, MD  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 26 1986  |  | 25b. REGISTRAR'S SIGNATURE<br>A. J. Gordon-Randall   |                              |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

2020 COLLECTION

PHILIP W. BOWEN

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*



|   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|---|--|--|---|--|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST<br>Vernon   |  |  | MIDDLE<br>L.  |  |  | LAST<br>Gough   |  |  | 2b. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR |  |  | 2c. DATE OF DEATH<br>MONTH DAY YEAR   |  |  | 2d. HOUR<br>p.m.                             |  |  |
| 3. SEX<br>MALE  |  |  | 4. RACE<br>BLACK  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4-26-42   |  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>44 YRS.   |  |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>11-15 1986                            |  |  | 7d. HOUR<br>5:00 p.m.                        |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALTO., MD.  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel County, MD.                                |  |  |   |  |  |   |  |  |  |  |  |
| 11. CITY OR TOWN OF DEATH<br>BALTIMORE  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Race Road |  |  |   |  |  |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                           |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |
| 13a. STATE<br>MARYLAND  |  |  | 13b. COUNTY   |  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS<br>5309 READY AVENUE  |  |  |   |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>FRANCIS GOUGH   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>RUTH MILES   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.<br>137-34-6799   |  |  | 17. INFORMANT<br>JEAN GOUGH 5309 READY AVE  |  |  |   |  |  |   |  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple Gunshot Wounds (unspecified)<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |   |  |  |   |  |  |   |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  | 21b. TIME OF INJURY (est.)<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. 11-15 1986   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject was shot   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> ?  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>?  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE  |  |  | M.D. Assistant  |  |  | MEDICAL EXAMINER  |  |  | DATE SIGNED 11-16-86  |  |  |   |  |  |   |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |  | Gregory R. Kauffman, M.D.   |  |  | ADDRESS 111 Penn St., Balto., Md. 21201   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  |  | 23b. DATE<br>11-21-86   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MD. NAT. MEM. PK.   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE, MARYLAND                               |  |  |   |  |  |   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  |  | BROWN THOMPSON F.H.   |  |  | ADDRESS<br>1913 W. BALTIMORE  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 19 1986  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Denton-Randall                                      |  |  |   |  |  |  |  |  |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 5. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This release form is carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|
| 1 - FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |   |  |   |  |   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Edward Francis Grape<br>EDWARD FRANCIS GRAPE   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11/4/86  |  |   |  | 2b. HOUR<br>400A <sub>M</sub>   |  |   |  |
| 3. SEX<br>Male<br>MALE   |  | 4. RACE<br>Caucasian<br>Cauc.   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 24 15   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71<br>YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)<br>MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Crownsville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>720 Whitneys Landing Drive |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Vice Pres.  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Flooring  |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY<br>A. A.  |  | 13c. CITY OR TOWN<br>Crownsville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br>720 Whitneys Landing Drive 21032  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Clarence E. Grape  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Genevieve Sullivan   |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>NO   |  | 17. INFORMANT<br>Mary Eileen Grape<br>720 Whitneys's Landing Drive 21032  |  |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Metastatic Adenocarcinoma of Colon</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Severe acute Respiratory Compromise</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u>   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 3</u> , 19 <u>86</u> , to <u>Nov 4</u> , 19 <u>86</u> , that (I) (we) lost<br>saw the deceased alive on <u>Nov 3</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If not, (did) (did not) view the body after death)  |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Ronald C. Sroka</u>   |  |   |  | DEGREE<br>MD  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF<br>DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>11/4/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RONALD C. SROKA MD.   |  |   |  | 22e. ADDRESS<br>3 VILLAGE GREEN CROFTON, MD 21114   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>11-7-86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. PK   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Elkridge Howard MD  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>MacNabb Funeral Home   |  |   |  | ADDRESS<br>MD 21228   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 5 1986   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Jean Anderson-Randall</u>  |  |

MEDICAL CERTIFICATION

0-5303

RECEIVED



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

IMPORTANT: If item 21 is marked as item 18 above any injury, or other incident, the medical examiner must be notified at once.

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |   |                                   |  |  |
|--|--|--|--|--|--|--|--|---|-----------------------------------|--|--|
| FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |   |                                   | 2b. HOUR   |  |
|  |  | Alfred August Grau, Sr.  |  |  |  | 11 14 86   |  |   |                                   | 8 15 AM  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |   |                                   | IF UNDER 1 YEAR MONTHS DAYS                                      |  |
| Male   |  | White  |  | Aug 3, 1904  |  | 82 YRS.  |  |   |                                   | IF UNDER 24 HRS. HOURS MIN.                                      |  |
| 7a. BIRTHPLACE (COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |                                   |  |  |
| Maryland   |  | USA  |  |  |  | Anne Arundel MD.   |  |   |                                   |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| Annapolis  |  | 1766 Duntan Road   |  |  |  | Retired  |  |   | Steele Erector                    |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE  |                                   |  |  |
| MD   |  | AA   |  | Annapolis  |  |  |  | 21403 909 Bay Ridge Avenue  |                                   |  |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)  |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |                                   |  |  |
| Max  |  | Lottie   |  | No   |  | 214-05-0960  |  | Dorothy B. Grau - Same as #13   |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u>   |  |  |  |  |  |  |  |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>5 MINUTES</u> |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CARCINOMA OF THE LUNG</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |  |  |  |   |                                   | <u>1 yr 10 mos.</u>  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Cerebrovascular Accident</u>  |  |  |  |  |  |  |  |   |                                   | <u>6 mos.</u>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>—</u>  |  |  |  |  |  |  |  |   |                                   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR MONTH DAY YEAR  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |                                   |  |  |
|  |  | P.M. 19  |  |  |  |  |  |   |                                   |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |                                   |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |  |  |  |  |   |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/4</u> , 19 <u>86</u> , to <u>11/14</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>11/4</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) did not view the body after death. |  |  |  |  |  |  |  |   |                                   |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  |  |  | 22c. DATE SIGNED   |  |   |                                   |  |  |
| Robert Scott Eden, M.D.  |  |  |  |  |  | 11/14/86   |  |   |                                   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  | 22f. REGISTRAR'S SIGNATURE   |  |   |                                   |  |  |
| ROBERT SCOTT EDEN, M.D.  |  | 703 GIDDINGS AVE. ANNAPOLIS, MD 21401  |  |  |  | Julia Gordon-Rudace  |  |   |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |                                   |  |  |
| Burial   |  | Nov 17, 1986   |  | Hillcrest  |  | Annapolis AA. MD   |  |   |                                   |  |  |
| 24. FUNERAL DIRECTOR NAME  |  | 24b. ADDRESS   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |                                   |  |  |
| Taylor Funeral Chapel, Annapolis, MD   |  |  |  |  |  | NOV 20 1986  |  |   |                                   |  |  |

BP

1. The first part of the report is a summary of the work done during the last year. It is a very good summary and gives a clear picture of the progress made. The second part is a detailed account of the work done during the last year. It is a very good account and gives a clear picture of the progress made. The third part is a summary of the work done during the last year. It is a very good summary and gives a clear picture of the progress made. The fourth part is a detailed account of the work done during the last year. It is a very good account and gives a clear picture of the progress made. The fifth part is a summary of the work done during the last year. It is a very good summary and gives a clear picture of the progress made. The sixth part is a detailed account of the work done during the last year. It is a very good account and gives a clear picture of the progress made. The seventh part is a summary of the work done during the last year. It is a very good summary and gives a clear picture of the progress made. The eighth part is a detailed account of the work done during the last year. It is a very good account and gives a clear picture of the progress made. The ninth part is a summary of the work done during the last year. It is a very good summary and gives a clear picture of the progress made. The tenth part is a detailed account of the work done during the last year. It is a very good account and gives a clear picture of the progress made.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, local authorities must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 6 3 0 3 5 0   |  | EST  |  |
|--|--|--|--|---|--|--|--|
| 1 - FOR<br>STATE<br>REGISTRAR  |  |  |  | CERTIFICATE OF DEATH  |  |  |  |
| REG. NO.   |  |  |  | EST   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>WALTER THEURLO GRAY Sr.  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>NOVEMBER 11, 1986   |  | 2b. HOUR<br>822 PM   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>2 13 05  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ANNE ARUNDEL COUNTY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>GLEN BURNIE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NORTH ARUNDEL HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Maintenance  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Chemical  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>A.A.  |  | 13c. CITY OR TOWN<br>Pasadena   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Walter T. Gray  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Annie Resch  |  | 13e. STREET ADDRESS / ZIP CODE<br>716 205th Street 21122  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>218-01-7517  |  | 17. INFORMANT ADDRESS<br>Mary E. Gray Same as 13e   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Ruptured abdominal aortic aneurysm</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>acute myocardial infarction and</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>cardiac arrest</i><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>acute renal failure</i> |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (checked) (did not view the body after death)  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Sang K. Han</i>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SANG K. HAN, M.D.   |  |  |  | 22e. ADDRESS<br>7845 OAKWOOD RD., SUITE 204<br>GLEN BURNIE, MARYLAND 21061  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>11/15/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem Park   |  | 23d. LOCATION<br>Glen Burnie A.A. Md   |  |
| 24. FUNERAL DIRECTOR<br>George J. Gonce 4001 Ritchie Hwy Balto Md  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 13 1986  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |

U



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove and retain pages 1 and 2 and file with the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. If item 21 is marked on item 18 shows any injury, or other traumatic, then the medical examiner must be notified.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic, then the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 30351

REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Rachel E Green</b>   |  | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>21</b> YEAR <b>86</b>                       |  | 2b. HOUR<br><b>M</b>  |  |
| 3. SEX<br><b>female</b>   |  | 4. RACE<br><b>B</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>01</b> DAY <b>22</b> YEAR <b>1895</b>  |  |
| 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>91</b>  |  | IF UNDER 1 YEAR<br>MONTHS <b>9</b> DAYS <b>1</b>  |  | IF UNDER 24 HRS<br>HOURS <b>9</b> MIN. <b>1</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY</b>  |  | 10. CITY OR TOWN OF DEATH<br><b>ANNAPOLIS</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ANNE ARUNDEL GENERAL HOSPITAL</b>           |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  | 13a. STREET ADDRESS / ZIP CODE<br><b>3437 RIVA ROAD 21035</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>A.A.</b>  |  | 13c. CITY OR TOWN<br><b>DAVIDSONVILLE</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>BENJAMIN</b> MIDDLE <b>STEPHNEY</b> LAST <b>JOHNSON</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MARY</b> MIDDLE <b>JOHNSON</b> LAST <b>JOHNSON</b> |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  |
| 16b. SOCIAL SECURITY NO.<br><b>218-30-3505</b>  |  | 17. INFORMANT<br><b>LOUISE M. MOULDEN</b>   |  | ADDRESS<br><b>3437 Riva Road Davidsonville, Md. 21035</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>atherosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>cardiac arrhythmias</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 yrs</b><br><b>2 yrs</b> |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><b>5 years decubitus ulcer, malnutrition</b>  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/1</b> , 19 <b>83</b> , to <b>11/21</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>11/20</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Paul B. Perez MD</b>   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>11/21/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS<br><b>6953491 Cotton MD 21114</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>11-26-1986</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PINELAWN MEM. PARK</b>   |  |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Annapolis, A.A. Maryland</b>  |  | 23e. COUNTY<br><b>A.A.</b>  |  | 23f. STATE<br><b>Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 24 1986</b>                                     |  | 25b. REGISTRAR'S SIGNATURE<br><b>John</b>   |  |

BP

0052500 10052500

10052500 10052500

10052500 10052500

10052500 10052500

10052500 10052500

10052500 10052500

10052500 10052500

10052500 10052500

10052500 10052500

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |                                    |  |  |  |  |  |  |
|--|--|---|--|---|------------------------------------|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GEORGE Clayton GROSS, Jr.</b>         |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>11 30 86</b> |   |                                    | 2b. HOUR <b>12:15A M</b>   |  |  |  |  |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>5 10 18 68</b>   |                                    | 6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b>                                    |  | 7. IF UNDER 1 YEAR IF UNDER 24 HRS<br>MONTHS DAYS HOURS MIN. |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>                |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.                 |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Annapolis</b>                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hospital</b> |  |   |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Air Force</b>      |  |  |  |
| 13a. STATE <b>MD</b>   |  |   | 13b. COUNTY <b>A.A.</b>                          |   | 13c. CITY OR TOWN <b>Annapolis</b> |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE <b>1959 Valley Road 21401</b> |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>George C. Gross, Sr.</b>              |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mabel Inschweiler</b>   |                                    |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b> |  |   | 16b. SOCIAL SECURITY NO. <b>1-16-07-8166</b>     |   |                                    | 17. INFORMANT <b>Jean L. Gross-</b>  |  |  | ADDRESS <b>Same as #13</b>                                   |  |  |

|  |  |  |  |
|--|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-RESP ARREST</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CONGESTIVE HEART FAILURE</b>  |  | <b>YES</b>                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CARDIOMYOPATHY</b>  |  | <b>YES.</b>                                  |  |

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>RENAL FAILURE</b>   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>Barry R. Nathanson</b> DEGREE   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <b>11/30/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BARRY R. NATHANSON</b>   |  |   |  | 22e. ADDRESS <b>51 FRANKLIN ST. ANNAP, MD 21401</b>  |  |   |  |

|  |  |                              |  |  |  |  |  |
|--|--|------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                      |  | 23b. DATE <b>Dec 31 1986</b> |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Maryland Veterans</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crownsville AA MD</b> |  |
| 24. FUNERAL DIRECTOR NAME <b>Taylor Funeral Chapel Annapolis, MD</b> ADDRESS |  |                              |  | 25a. DATE REC'D. BY REGISTRAR <b>DEC 3 1986</b> 25b. REGISTRAR'S SIGNATURE <b>Julia Anderson-Rodriguez</b> |  |  |  |

BP

1

1. COMBIBILE  
2. COMBIBILE  
3. COMBIBILE  
4. COMBIBILE  
5. COMBIBILE  
6. COMBIBILE  
7. COMBIBILE  
8. COMBIBILE  
9. COMBIBILE  
10. COMBIBILE  
11. COMBIBILE  
12. COMBIBILE  
13. COMBIBILE  
14. COMBIBILE  
15. COMBIBILE  
16. COMBIBILE  
17. COMBIBILE  
18. COMBIBILE  
19. COMBIBILE  
20. COMBIBILE  
21. COMBIBILE  
22. COMBIBILE  
23. COMBIBILE  
24. COMBIBILE  
25. COMBIBILE  
26. COMBIBILE  
27. COMBIBILE  
28. COMBIBILE  
29. COMBIBILE  
30. COMBIBILE  
31. COMBIBILE  
32. COMBIBILE  
33. COMBIBILE  
34. COMBIBILE  
35. COMBIBILE  
36. COMBIBILE  
37. COMBIBILE  
38. COMBIBILE  
39. COMBIBILE  
40. COMBIBILE  
41. COMBIBILE  
42. COMBIBILE  
43. COMBIBILE  
44. COMBIBILE  
45. COMBIBILE  
46. COMBIBILE  
47. COMBIBILE  
48. COMBIBILE  
49. COMBIBILE  
50. COMBIBILE  
51. COMBIBILE  
52. COMBIBILE  
53. COMBIBILE  
54. COMBIBILE  
55. COMBIBILE  
56. COMBIBILE  
57. COMBIBILE  
58. COMBIBILE  
59. COMBIBILE  
60. COMBIBILE  
61. COMBIBILE  
62. COMBIBILE  
63. COMBIBILE  
64. COMBIBILE  
65. COMBIBILE  
66. COMBIBILE  
67. COMBIBILE  
68. COMBIBILE  
69. COMBIBILE  
70. COMBIBILE  
71. COMBIBILE  
72. COMBIBILE  
73. COMBIBILE  
74. COMBIBILE  
75. COMBIBILE  
76. COMBIBILE  
77. COMBIBILE  
78. COMBIBILE  
79. COMBIBILE  
80. COMBIBILE  
81. COMBIBILE  
82. COMBIBILE  
83. COMBIBILE  
84. COMBIBILE  
85. COMBIBILE  
86. COMBIBILE  
87. COMBIBILE  
88. COMBIBILE  
89. COMBIBILE  
90. COMBIBILE  
91. COMBIBILE  
92. COMBIBILE  
93. COMBIBILE  
94. COMBIBILE  
95. COMBIBILE  
96. COMBIBILE  
97. COMBIBILE  
98. COMBIBILE  
99. COMBIBILE  
100. COMBIBILE



023506

NOV 12

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |   |   |
|--|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Luke B. Hall                               |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov. 1, 1986   |   | 2b. HOUR<br>M   |
| 3. SEX<br>Male   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb 6, 1902   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel MD.        |   |
| 10. CITY OR TOWN OF DEATH<br>Annapolis   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Annapolis Convalescent Ctr. |   | 12a. USUAL OCCUPATION<br>(GIVE OR GIVE MOST OF WORKING LIFE)<br>Equipment Operator              |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>BACo                       |
| 13a. STATE<br>MD   | 13b. COUNTY<br>AA  | 13c. CITY OR TOWN<br>Annapolis  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>Glenwood Street-21401         |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William F. Hall  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ella Buckmaster  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO |  | 16b. SOCIAL SECURITY NO.<br>216-30-1302   |   | 17. INFORMANT<br>ADDRESS<br>Esther Stokes - Annapolis, MD 21403 |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

|   |  |  |   |  |   |
|---|--|--|---|--|---|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 8, 1986, to date, 1986, that (I) (we) lost<br>saw the deceased alive on Nov 1, 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. I (we) (did not) view the body after death. |  |  |   |  |   |
| 22b. SIGNATURE<br>Michael J. Roberts  |  | DEGREE   |   | 22c. DATE SIGNED<br>11/3/86  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Michael J. Roberts   |  | 22e. ADDRESS<br>703 GIDDINGS ST ANNAPOLIS MD 21403                     |   |  |   |

MEDICAL CERTIFICATION

|   |                           |   |  |
|---|---------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                      | 23b. DATE<br>Nov. 4, 1986 | 23c. NAME OF CEMETERY OR CREMATORY<br>Wesley  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Prince Frederick Cal. MD |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Taylor Funeral Chapel-Annapolis, MD |                           | 25a. DATE REC'D. BY REGISTRAR<br>NOV - 6 1986 | 25b. REGISTRAR'S SIGNATURE<br>Julia Tridopoulos-Rudner                 |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial front permit. Then please remove page 3 and file with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



025888 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO.  |  | EST  |   |
|---|--|---|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>VIRGINIA NORA HAMMOND   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 20, 1986  |  | 2b. HOUR<br>658 PM   |   |
| 3. SEX<br>female  |  | 4. RACE<br>white  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>03-12-1922  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ANNE ARUNDEL COUNTY MD   |   |
| 10. CITY OR TOWN OF DEATH<br>GLEN BURNIE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NORTH ARUNDEL HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>housewife   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>own home  |   |
| 13a. STATE<br>MD  |  |   |  | 13b. CITY OR TOWN<br>Glen Burnie  |  | 13c. STREET ADDRESS / ZIP CODE<br>907 Phyllen Court 21061  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>nfn   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>nmn  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>283-32-6884  |  | 17. INFORMANT ADDRESS<br>Mr. Leo R. Hammond, Glen Burnie, MD - husband  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>asystole</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>brain death</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>acute myocardial infarction</u>   |  |   |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><u>end-stage pulmonary emphysema</u>  |  |   |  |   |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>about 1983</u> , 19____, to <u>11/20</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>11/19/86</u> , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |   |
| 22b. SIGNATURE<br><u>J. Benjamin</u>  |  |   |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>11/23/86   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JAMES J. BENJAMIN, M.D.  |  |   |  | 22e. ADDRESS<br>653 OLD MILL ROAD<br>MILLERSVILLE, MARYLAND 21108   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>11-23-1986   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Tabor Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Oldtown Allegany MD  |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>James F. Scarpelli, Cumberland, MD 21502  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 01 1986  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John Benjamin</u>   |   |



052005 000-312

3

DEC 01 1981

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 0 3 5 5

REG. NO.

24287 NOV 18 1986

|  |  |   |  |   |   |
|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Irma E. Harrison  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov. 11, 1986  |  | 2b. HOUR<br>0645 AM   |   |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 1, 1907  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 10. CITY OR TOWN OF DEATH<br>Annapolis   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Anne Arundel Gen. Hosp |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel MD.  |   |
| 12a. USUAL OCCUPATION<br>(NAME OF WORK FOR MOST OF WORKING LIFE)<br>Ret. Secretary   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Office   |  |   |   |
| 13a. STREET ADDRESS / ZIP CODE<br>422 Third St. 21403  |  | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                     |  |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John A. Wisenauer  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Annie E. Deck  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-03-4264  |  | 17. INFORMANT<br>ADDRESS<br>Same as #13   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute respiratory failure with hepatic</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Emphysema &amp; COPD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 week<br>Cause |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>ASMA &amp; atrial fibrillation</u> <u>Alzheimer's disease</u>  |  |   |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT HOME   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>11/5 86 to 11/11 86  |   |
| 22a. I certify that (1) (this hospital) attended the deceased from 11/5 86 to 11/11 86, and that (2) (my) opinion of death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.   |  |   |  |   |   |
| 22b. SIGNATURE<br><u>S. David Krims</u>  |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>11/11/86  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>S. David Krims, MD  |  | 22e. ADDRESS<br>25 Shaw St. Annapolis, MD 21401   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Nov. 13, 1986  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven  |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie AA MD  |  | 23e. DATE REC'D. BY REGISTRAR<br>NOV 14 1986  |  |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Taylor Funeral Chapel - Annapolis, MD  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Gordon-Rodner   |  |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.



025439 DEC 11 86

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

86 30350

|  |  |   |  |   |   |
|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Emma J. Hedin</i>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>11-23-86</i>                               |   | 2b. HOUR<br>MIN.<br><i>1:50</i> M   |
| 3. SEX<br><i>F</i> EMALE   | 4. RACE<br><i>WHITE</i>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>6-29-17</i>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>69</i> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>VIRGINIA</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>ANNE ARUNDEL COUNTY</i> MD.               |   |   |
| 10. CITY OR TOWN OF DEATH<br><i>ANNAPOLIS ANNE</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>ARUNDEL GENERAL HOSPITAL</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>HOMEMAKER</i> | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. STATE<br><i>MARYLAND</i>  |  |   | 13b. COUNTY<br><i>ANNE ARUNDEL</i>   | 13c. CITY OR TOWN<br><i>MAYO</i>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>WILLARD EVANS</i>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>CELIA PRUITT</i>                 |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>NO</i>   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>ADDRESS<br><i>WALD. D. HEDIN P.O. BOX 997 VERO BEACH FLA. 32906</i>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Metastatic Cancer</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma, colon.</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic obstructive Pulmonary disease.</i>  |  |   |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |   |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>11/24 79</i>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT HOME   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><i>205 Ridgely Ave Annapolis MD</i>  |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/19</i> 19 <i>86</i> , to <i>11/23</i> 19 <i>86</i> ; that (I) (we) lost saw the deceased alive on <i>11/19</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) see the body after death. |  |   |  |   |   |
| 22b. SIGNATURE<br><i>George P. Samaras</i>   |  | DEGREE  |  | 22c. DATE SIGNED<br><i>11/24/86</i>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>George P. Samaras</i>  |  | 22e. ADDRESS<br><i>205 Ridgely Ave Annapolis MD</i>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>BURIAL</i>  | 23b. DATE<br><i>11-25-86</i>   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>LAKEMONT CEMETERY</i>  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>DAVIDSONVILLE A.A.CO. MD</i>        |   |   |
| 24. FUNERAL DIRECTOR<br><i>ROBERT E. EVANS 1212 WEST STREET ANNAPOLIS MD</i>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 28 1986</i>                                  |   |   |
|  |  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Davidson-Randall</i>                                |   |   |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the non-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal, or other disposition of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

10/10/11

10/10/11

10/10/11

10/10/11

10/10/11

10/10/11

10/10/11

10/10/11

10/10/11

10/10/11

1

10/10/11

10/10/11

10/10/11

10/10/11

10/10/11

10/10/11

024031 NOV 14 1986

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 3 0 3 5 EST  
REG. NO.

|   |  |  |  |  |  |   |  |  |
|---|--|--|--|--|--|---|--|--|
| FOR<br>STATE<br>REGISTRAR   |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  | REG. NO.  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>FRANK W HELMETAG</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 08, 1986</b>  |  |  | 2b. HOUR<br><b>0903 AM</b>  |  |  |
| 3. SEX<br><b>Male</b>   |  |  | 4. RACE<br><b>White</b>  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 7 1909</b>   |  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.   |  |  | 7. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD</b>  |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Chauffeur</b>  |  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balt. City</b>  |  |  | 13a. STREET ADDRESS / ZIP CODE<br><b>8091 Forrest Glen Dr. 21122</b>   |  |  |   |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Anne Arundel</b>   |  |  | 13c. CITY OR TOWN<br><b>Pasadena</b>  |  |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>8091 Forrest Glen Dr. 21122</b>   |  |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank J. Helmetag</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hadie (Unknown)</b>  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>214 03 5467</b>   |  |  | 17. INFORMANT<br>ADDRESS<br><b>Thelma Helmetag (Same as 13a-e)</b>  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Spinal Hemorrhage,</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>probably metastatic</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).   |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION<br><b>10/22/86</b>   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Removal of cerebral spine</b>   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (If this hospital, the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, please state when and where the body was viewed after death.)   |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Charles J. Lancelotta, Jr., M.D.</b>   |  |  | DEGREE<br><b>M.D.</b>  |  |  | 22c. ADDRESS<br><b>325 HOSPITAL DRIVE, SUITE 105 GLEN BURNIE, MARYLAND 21061</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHARLES J. LANCELOTTA, JR., M.D.</b>  |  |  | 22e. ADDRESS<br><b>325 HOSPITAL DRIVE, SUITE 105 GLEN BURNIE, MARYLAND 21061</b>   |  |  | 22f. DATE SIGNED<br><b>11/10/86</b>   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>Nov. 11, '86</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Western Cemetery</b>   |  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City MD</b>  |  |  | 23e. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1986</b>  |  |  | 23f. REGISTRAR'S SIGNATURE<br><b>John S. ...</b>  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>McCully Funeral Home</b>   |  |  | ADDRESS<br><b>33204 Mountain Rd. Pasadena, MD 21122</b>  |  |  | 24b. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1986</b>   |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1031 1031

WINTER, OR, 1902

WINTER, OR, 1902

WINTER, OR, 1902

WINTER, OR, 1902

WINTER, OR, 1902

WINTER, OR, 1902

WINTER, OR, 1902

WINTER, OR, 1902



025440 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR STATE REGISTRAR  |  |                    |  |   |  |  |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE                     |  |  |  |  |  |   |  |  |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REG. NO. 30358 |  |  |  |  |  |  |  |  |  |
|--|--|--------------------|--|---|--|--|--|---|--|---|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|----------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Johnston S. Hepburn</b>  |  |                    |  |   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH ESTIMATED <b>11/18/86</b>           |  |  |  |  |  |   |  |  |  | 2b. HOUR <b>11</b>   |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |
| 3. SEX <b>MALE</b>   |  | 4. RACE <b>CAU</b> |  | 5. DATE OF BIRTH <b>1/4/21</b>  |  | 6. AGE (IN YEARS) <b>65</b> YRS.   |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN  |  | 7c. DATE PRONOUNCED DEAD <b>11/21/86</b>                    |  | 7d. HOUR <b>1755</b>   |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MASS</b>  |  |                    |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>AA</b>   |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Annapolis</b>   |  |                    |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Home Address</b> |  |  |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TEACHER SEVERN</b>          |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>SCHOOL</b> |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |
| 13a. STATE <b>MD</b>   |  |                    |  | 13b. COUNTY <b>AA</b>   |  |  |  | 13c. CITY OR TOWN <b>Annapolis</b>  |  |   |  | 13d. INSIDE-CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  | 13e. STREET ADDRESS <b>40 West St. #1401</b>    |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST <b>James</b> MIDDLE <b>P</b> LAST <b>Hepburn</b>   |  |                    |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Bessie</b> MIDDLE <b>Huse</b> LAST <b>Huse</b> |  |   |  |   |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>  |  |                    |  |   |  | 16b. SOCIAL SECURITY NO. <b>031-22-4841</b>                                      |  |   |  |   |  | 17. INFORMANT ADDRESS <b>B. BRUCE HOGG RT. 1 BOX 252</b>                                     |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest.</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: <b>A.S.C. V.D.</b><br>(b) <b>Due to, or as a consequence of</b><br>(c) <b>Due to, or as a consequence of</b>   |  |                    |  |   |  |  |  |   |  | QUEENSTOWN, MD. 21658                                       |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |                    |  |   |  |  |  |   |  |   |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                    |  |   |  |  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |  |  |  |  |   |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                    |  |   |  |  |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19        |  |  |  |  |  |   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)    |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                    |  |   |  |  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |  |  |  |  |   |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                   |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                    |  |   |  |  |  |   |  |   |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>William P. Jones</b> M.D. <b>Deputy</b> MEDICAL EXAMINER   |  |                    |  |   |  |  |  |   |  | DATE SIGNED <b>11-21-86</b>                                 |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>William P. Jones, M.D.</b>  |  |                    |  |   |  |  |  |   |  | ADDRESS <b>695 America Crt., Davidsonville, Md. 21035</b>   |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>CREMATION</b>   |  |                    |  |   |  |  |  |   |  | 23b. DATE <b>11-22-86</b>                                   |  |  |  |  |  |   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>METROPOLITAN CREMATORY</b>                 |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>ROBERT E. EVANS</b>   |  |                    |  |   |  |  |  |   |  | ADDRESS <b>1212 WEST ST. ANNAPOLIS, MD.</b>                 |  |  |  |  |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1986</b>                                 |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE <b>Robert E. Evans</b>  |  |                    |  |   |  |  |  |   |  |   |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

1. The first part of the report is a summary of the work done during the last year. This includes a description of the various projects which have been completed, and a statement of the results obtained. The second part of the report is a detailed account of the work done during the last year. This includes a description of the various projects which have been completed, and a statement of the results obtained.



1. The first part of the report is a summary of the work done during the last year. This includes a description of the various projects which have been completed, and a statement of the results obtained. The second part of the report is a detailed account of the work done during the last year. This includes a description of the various projects which have been completed, and a statement of the results obtained.

2. The second part of the report is a detailed account of the work done during the last year. This includes a description of the various projects which have been completed, and a statement of the results obtained. The third part of the report is a detailed account of the work done during the last year. This includes a description of the various projects which have been completed, and a statement of the results obtained.

025070 NOV 25

FOR  
DATE  
REGISTERSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

30357

REG. NO.

|  |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CHARLES T. HICKMAN</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 19, 1986</b>   |  |  |  | 2b. HOUR<br>M  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 10, 1917</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel Co.</b> MD.                              |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Brooklyn Pk.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>4505 Ritchie Hwy.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mechanic</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Automotive</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |  |  |  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>A.A.</b>  |  | 13c. CITY OR TOWN<br><b>Brooklyn Pk.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>4505 Ritchie Hwy. (21225)</b>                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ernest Hickman</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ruth Thomas</b>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>217-01-8756</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Charles E. Hickman, 806 Old Riverside Rd. Baltimore, MD 21225</b> |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>coronary artery Dis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>COPD</b>  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 hrs</b><br><b>10 yrs</b><br><b>15 yrs</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                      |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> WORK<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   |  | 21e. PLACE OF INJURY<br>STREET CITY OR TOWN COUNTY STATE  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>6/14/84</b> , 19____, to <b>11/10/86</b> , 19____, that (1) (we) last saw the deceased alive on <b>11/10/86</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Silvino B. Muneses</b>  |  |   |  | DEGREE<br><b>SILVINO B. MUNESSES, M.D., PH.D.</b>   |  |  |  | 22c. DATE SIGNED<br><b>11-20-86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Silvino B. Muneses MD.</b>   |  |   |  | 22e. ADDRESS<br><b>3721 BALTIMORE, MD 21225</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/22/86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Men. Pk.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                         |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>George J. Gonce, 4001 Ritchie Hwy., Baltimore, MD (21225)</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 24 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                                    |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial transit permit. Then please return the certificate to the funeral director. Pages 1 and 2 should be filed with the 72-hour after death report with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18, shows any injury, or other traumatic event, the medical examiner must be notified in person.

BP

207-662-1187  
BALTIMORE, MD 21228  
821 Potomac Street  
SILVINO B. BROWN, JR., MD, PhD

24262 NOV 18 1986

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 30360

REG. NO.

|  |  |   |   |   |   |
|--|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Edna Mae Hodgkiss   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 11-11-86  |   | 2b. HOUR<br>8:20pm  |
| 3. SEX<br>Female   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>08 - 27 - 1898  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS.                                | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 72 HRS<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel Co. MD.              |   |
| 10. CITY OR TOWN OF DEATH<br>Annapolis   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Anne Arundel General Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Mother                      | 12b. KIND OF BUSINESS OR INDUSTRY<br>Housework                            |   |
| 13a. STATE<br>Md.  | 13b. COUNTY<br>A.A.  | 13c. CITY OR TOWN<br>Severna Park   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>396 Stonthouse Dr./21146                |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Thompson   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Amis  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>---  | 17. INFORMANT ADDRESS<br>Mr. James E. Hodgkiss (same as 13)                                     |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>days</u>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |   |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/11</u> , 19 <u>86</u> , to <u>11/11</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>11/11</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |   |   |   |   |
| 22b. SIGNATURE<br><u>James Chaconas MD</u>   |  | DEGREE<br>ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/><br>PHYSICIAN DIRECTOR PHYSICIAN     |   | 22c. DATE SIGNED<br><u>11/12/86</u>                                       |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>James Chaconas  |  | 22e. ADDRESS<br>1521 Ritchie Hwy Arnold Md.   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  | 23b. DATE<br>11-12-1986  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Cemetery   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Westview Balt. Co. Md.                            | 24. FUNERAL DIRECTOR<br>NAME<br>BARRANCO F.H. SEVERNA PARK Md. 21146      |   |
| 25a. DATE REC'D. BY REGISTRAR<br>NOV 14 1986   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Tindon-Randall  |   |   |   |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the attending physician must be notified as soon as possible.

24 205 10 18 02

24 205 10 18 02

24 205 10 18 02



24 205 10 18 02

125223 NOV 25 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30361

|  |                    |   |   |  |  |   |   |   |  |
|--|--------------------|---|---|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>John E. Hoff</b>  |                    |   |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>11</b> DAY <b>21</b> YEAR <b>1986</b>   |  |   |   | 2b. HOUR <b>AM</b>  |  |
| 3. SEX <b>M</b>  | 4. RACE <b>CAU</b> | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>27</b> YEAR <b>1965</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>21</b> YRS. | IF UNDER 1 YR.<br>MONTHS <b>0</b> DAYS <b>0</b>  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>                               | 2c. DATE PRONOUNCED DEAD <b>11 21 1986</b>  |   | 2d. HOUR <b>0452</b> <b>AM</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>  |                    | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>AA</b> <b>MD.</b>                                     |   |   |  |
| 10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>   |                    | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Arundel</b> |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chauffeur</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>Food</b>                                     |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                    |   |   |  |  |   |   |   |  |
| 13a. STATE <b>MD</b>   |                    | 13b. COUNTY <b>AA</b>   |   | 13c. CITY OR TOWN <b>Glen Burnie</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 13e. STREET ADDRESS <b>101 Queen Anne Rd</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>WILLIAM</b> MIDDLE <b>J.</b> LAST <b>HOFF</b>  |                    |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>EVELYN</b> MIDDLE <b>P.</b> LAST <b>MAUERHAN</b>  |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>NO</b> (IF YES, GIVE WAR OR DATES)  |                    |   |   | 16b. SOCIAL SECURITY NO. <b>216 34 7983</b>  |  | 17. INFORMANT <b>Glen Burnie, Maryland 21061</b><br><b>Evelyn P. Hoff 101 Queen Anne Road</b> |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple Trauma, Extreme</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <b>8199</b><br>(b) <b>Motor Vehicle Accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |                    |   |   |  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |                    |   |   |  |  |   |   |   |  |
| 19a. DATE OF OPERATION   |                    |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>0400 AM 11-26 1986</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Motor Vehicle Accident</b>  |  |   |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK  |                    | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Street</b>   |   | 21f. LOCATION<br>STREET <b>Marley Neck Rd.</b> CITY OR TOWN <b>AA</b> COUNTY <b>AA</b> STATE <b>MD.</b>  |  |   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                    |   |   |  |  |   |   |   |  |
| ACTUAL SIGNATURE <b>William P. Jones</b>   |                    |   |   | TITLE (SPECIFY) <b>Deputy</b> M.D. MEDICAL EXAMINER  |  |   |   | DATE SIGNED <b>11-21-86</b>   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>William P. Jones, M.D.</b>  |                    |   |   | ADDRESS <b>695 America Crt. Davidsonville, Md. 21035</b>   |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |                    | 23b. DATE <b>11/24/86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Park</b>  |  |   | 23d. LOCATION<br>CITY OR TOWN <b>Glen Burnie</b> COUNTY <b>AA</b> STATE <b>MD</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Raymond E. Fink</b> ADDRESS <b>Glen Burnie, Md 21061</b>   |                    |   |   | 25a. DATE REC'D. BY REGISTRAR <b>24 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>   |   |   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER WITH FORM PENDING. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSFER FORM. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



W. A. D.

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card from this certificate. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition of the body. Page 4 may be retained by the funeral director. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic cause of death, a medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |   |   |                                |  |   |  |
|---|--|---|--|---|---|---|--------------------------------|--|---|--|
| 1- FOR STATE REGISTRAR  |  |   |  |   |   |   |                                |  |   |  |
| 8 8 3 0 3 6 2   |  |   |  |   |   |   |                                |  |   |  |
| REG. NO.  |  |   |  |   |   |   |                                |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>WILMA E. HOFF  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>11 5 86                   |   |                                | 2b. HOUR<br>M  |   |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>AUG. 15, 1921   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65   |                                | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>CALIF.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ANNE ARUNDEL CO. MD.                  |                                |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>ANNAPOLIS  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ANNE ARUNDEL GENERAL HOSP. |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE |                                | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOUSEHOLD   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD.   |  |   |  |   | 13b. COUNTY<br>A.A.   |   | 13c. CITY OR TOWN<br>ANNAPOLIS |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WILLIAM HAGE  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>HELEN BRANDT |   |                                |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>NO   |  | 17. INFORMANT ADDRESS<br>Bernard C. Huff Jr. same as 13   |   |   |                                |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Adeno Carcinom -</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |   |  |   |   |   |                                |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____   |  |   |  |   |   |   |                                |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |                                |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |                                |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1984</u> , 19____, to <u>11/5/86</u> , 19____, that (I) (we) lost<br>saw the deceased alive on <u>11/4/86</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |   |                                |  |   |  |
| 27b. SIGNATURE<br><u>Stanley Watkins</u>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   |   |                                | 27c. DATE SIGNED<br>11/6/86  |   |  |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Stanley Watkins  |  |   |  | 27e. ADDRESS<br>51 Franklin St, Annapolis, Md. 21401  |   |   |                                |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>11/8/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>LAKEMONT CEM  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>DAVIDSONVILLE A.A. MD.          |                                |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>HARDESTY FUN. HOME  |  |   |  | 12RIDGELEY AVE. ANN. MD.  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 12 1986                                  |                                | 25b. REGISTRAR'S SIGNATURE<br><u>Julia ...</u>   |   |  |

02 01 01 2 10 03



5

24257 NOV 18 86

1- FOR STATE REGISTRAR

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8 0 3 0 3 0 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
**MORRIS HOFFMAN**

2a. DATE OF DEATH MONTH DAY YEAR  
**NOVEMBER 7, 1986**

2b. HOUR  
**8:43 A.M.**

3. SEX  
**MALE**

4. RACE  
**CAUCASIAN**

5. DATE OF BIRTH MONTH DAY YEAR  
**OCT. 13, 1916**

6. AGE (IN YEARS LAST BIRTHDAY)  
**70**

IF UNDER 1 YEAR MONTHS DAYS  
 IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
**MARYLAND**

7b. CITIZEN OF WHAT COUNTRY?  
**USA**

8. MARRIED ☒ NEVER MARRIED ☐  
 WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
**ANNE ARUNDEL COUNTY MD.**

10. CITY OR TOWN OF DEATH  
**GLEN BURNIE**

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY OR COUNTY)  
**NORTH ARUNDEL GEN HOSPITAL**

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
**ADMINISTRATOR**

12b. KIND OF BUSINESS OR INDUSTRY  
**COLLEGE OF COMM.**

13a. STATE  
**MARYLAND**

13b. COUNTY  
**BALTIMORE**

13c. CITY OR TOWN  
**BALTIMORE**

13d. STREET ADDRESS / ZIP CODE  
**2910 TERRY DR., APT. E (21209)**

14. FATHER'S NAME FIRST MIDDLE LAST  
**ABRAHAM HOFFMAN**

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
**FREDA MILLER**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  
**NO**

16b. SOCIAL SECURITY NO.  
**220-14-1582A**

17. INFORMANT  
**MRS. EDITH HOFFMAN APT. E 2910 TERRY DR. BALTO., MD 21209**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
 PART I. DEATH WAS CAUSED BY:  
 IMMEDIATE CAUSE (a) Acute Myocardial Infarction.  
 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease  
 DUE TO, OR AS A CONSEQUENCE OF (c) \_\_\_\_\_  
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):  
Hypertension, Anxiety Neurosis

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?  
 YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  
 YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINERS)  
☐

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
**P.M. 19**

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 19\_\_ to 11.7. 1986 that (I) (we) last saw the deceased alive or above; (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE  
**S.D. Auzla**

22c. DATE SIGNED  
**11/7/86**

22d. PHYSICIAN'S NAME (TYPE OR PRINT)  
**S.D. Auzla**

22e. ADDRESS  
**3400 OLD COURT RD. RANDALLSTOWN MD 21133**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
**BURIAL**

23b. DATE  
**NOV. 9, 1986**

23c. NAME OF CEMETERY OR CREMATORY  
**BALTIMORE HEBREW**

23d. LOCATION CITY OR TOWN COUNTY STATE  
**BALTIMORE MARYLAND**

24. FUNERAL DIRECTOR SOL LEVINSON & bro., inc. 6010 REISTERSTOWN RD. BALTO, MD 21215

25a. DATE REC'D BY REGISTRAR  
**NOV 14 1986**

25b. REGISTRAR'S SIGNATURE  
*[Signature]*

BP

DHMH - 16 60M 7/B4 (VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper, page 1 and 2 should be kept with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

2001.01.10



024753 NOV 21-86

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 0 3 6 4

REG. NO.

|  |  |  |  |   |   |   |  |  |  |  |
|--|--|--|--|---|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Joseph Francis Hollywood, Jr.   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11-16-86                        |   |   | 2b. HOUR<br>2135M   |  |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11-02-20  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.                                  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel Co., MD.               |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Annapolis   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Anne Arundel General Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OR WORK FOR MOST OF WORKING LIFE)<br>Retired |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Professor |  |  |
| 13a. STATE<br>Maryland   |  |  |  |   | 13b. COUNTY<br>AA   |   | 13c. CITY OR TOWN<br>Annapolis   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Francis Hollywood Sr.   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Emma Dunn  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  |  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>1942-1944 077183521  |   | 17. INFORMANT<br>ADDRESS<br>Eugene Hollywood - Same as #13                           |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metastatic Transitional Cell Cancer<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>8 months.  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |  |   |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from 11/15, 1986, to 11/16, 1986, that (1) (we) lost<br>saw the deceased alive on 11/15, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) (did) (did not) view the body after death.                           |  |  |  |   |   |   |  |  |  |  |
| 22b. SIGNATURE<br>EW Cole II   |  |  |  |   | DEGREE<br>MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |  | 22c. DATE SIGNED<br>11/17/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>EW COLE II  |  |  |  |   | 22e. ADDRESS<br>57 FRANKLIN ST ANNAP. Md.   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK)<br>Burial   |  |  | 23b. DATE<br>Nov. 19, 1986   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Mary's  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Annapolis AA MD                        |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Taylor Funeral Chapel - Annapolis MD   |  |  |  |   | 25a. DATE REC'D BY REGISTRAR<br>NOV 20 1986   |   | 25b. REGISTRAR'S SIGNATURE<br>Julia Tindon-Rudolph                                   |  |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the medical examiner and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant condition, the medical examiner must be notified at once.

11-10-51

Joseph R. Thompson

11-10-51

11-10-51

Dear Mr. Thompson:

I have your letter of 11-10-51 regarding the matter of the

and I am sorry to hear that you are having trouble with it.

I will try to help you in any way I can.

Very truly yours,

John F. Kennedy

Enclosed for you are two copies of the report.

I hope this will be helpful to you.

Sincerely,  
John F. Kennedy



5  
023513 NOV

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove remaining pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the attending medical examiner must be notified at once.

DHMH - 16 60M 7/B4  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  | REG. NO.  |  |  |  |  |  |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARGARET Stover HOWARD</b>   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>11/ 4 86</b>  |  |  |  | 2b. HOUR <b>4:30 PM</b>                      |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>March 19, 1903</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.                                    |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Annapolis</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>838 Holly Drive East</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>  |  |  |  |
| 13a. STATE <b>MD</b>  |  | 13b. COUNTY <b>AA</b>   |  | 13c. CITY OR TOWN <b>Annapolis</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE <b>838 Holly Drive East 21401</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Porter Shipley Stover</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>unknown</b>  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO. <b>220-465475</b>  |  | 17. INFORMANT <b>Joan Howard Verner</b>   |  |   |  | ADDRESS <b>Star Route Box 13<br/>Bloomington, NY 14413</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic aortic disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/24</b> , 19 <b>84</b> , to <b>11/4</b> , 19 <b>86</b> , that (I) (we) lost<br>saw the deceased alive on <b>10/29</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death.                   |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE <b>Margaret M. Mullins, MD</b>   |  |   |  | DEGREE  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <b>11/5/86</b>              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Margaret M. Mullins MD</b>   |  |   |  | 22e. ADDRESS <b>Cape St. Claire - Annapolis, MD</b>   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Cremation</b>   |  | 23b. DATE <b>Nov. 6, 1986</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Southland PG MD</b>                               |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS <b>Taylor Funeral Chapel - Annapolis MD</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV - 6 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Julia T. ...</b>   |  |  |  |



024468 NOV 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5

3 0 3 0 6

REG. NO.

EST

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>EDGAR A. HOWELL   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 09 1986                                 |   | 2b. HOUR<br>305 AM   |
| 3. SEX<br>Male   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 26 1901  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ala.  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ANNE ARUNDEL COUNTY MD.                         |   |  |
| 10. CITY OR TOWN OF DEATH<br>GLEN BURNIE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NORTH ARUNDEL HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Minister            |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Methodist   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY P.G.   |   |   | 13c. CITY OR TOWN<br>Bowie  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edgar E. Howell  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anabel McCurdy                         |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |   | 16b. SOCIAL SECURITY NO.<br>401 20 7582   |   | 17. INFORMANT ADDRESS<br>Edna R. Howell 12614 Kornett Lane<br>Bowie, Maryland 20715             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ASCD</u>   |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT HOME   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/8</u> 19 <u>86</u> , to <u>11/9</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>11/8</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |   |   |   |   |  |
| 22b. SIGNATURE<br><u>[Signature]</u>   |   | DEGREE<br><u>M.D.</u>   |   | 22c. DATE SIGNED<br>11/9/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>H. J. GROSS, M.D.   |   | 22e. ADDRESS<br>5411 OLD FREDERICK ROAD<br>BALTIMORE, MARYLAND 21229  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  | 23b. DATE<br>11/13/86   | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Evergreen, Ala.                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Gary L. Kaufman Funeral Home   |   |   | 25. DATE RECD. BY REGISTRAR 26. REGISTRAR'S SIGNATURE<br>NOV 13 1986 <u>[Signature]</u> |   |  |
| 5695 Main St. Ellicott, Maryland 21227   |   |   |   |   |  |

10  
34  
35  
169  
2  
92  
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

051100 Nov 1952

11 28 1951

Wife

Wife

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married



Wife

Wife

Wife

Wife

Wife

Wife

NOV 13 1952

Wife

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |                       |   |  |   |                               |
|--|-----------------------|---|--|---|-------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Judson D. Hulsey</b>   |                       |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>11 27 1986</b> |   | 2b. HOUR<br>M<br><b>1900</b>  |
| 1. SEX<br><b>M</b>   | 4. RACE<br><b>CAU</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 3 26 60</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>26 YRS.</b>  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   | IF UNDER 24 HRS.<br>HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Gainesville Ga.</b>  |                       | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                               |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>AA</b>  |                       | MD.   |  |   |                               |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>  |                       | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Anne Arundel Gen</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clergyman</b>   |                               |
| 12b. KIND OF BUSINESS OR INDUSTRY  |                       |   |  |   |                               |
| 13a. USUAL RESIDENCE (IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADDRESS)<br>13b. STATE<br><b>Md.</b>   |                       | 13c. CITY OR TOWN<br><b>Woodbine</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                               |
| 13e. STREET ADDRESS<br><b>15922 A.E. Mullinix</b>  |                       |   |  |   |                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>RUFUS</b>   |                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Helen Dowling</b>   |  |   |                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>no</b>   |                       | 16b. SOCIAL SECURITY NO.<br><b>N-A 577-32-7685</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Patricia A. Hulsey #3E</b>   |                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>A.S.C.V.D.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |                       |   |  |   |                               |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |                       |   |  |   |                               |
| 19a. DATE OF OPERATION   |                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |                               |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                       | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                               |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                       |   |  |   |                               |
| ACTUAL SIGNATURE<br><b>William P. Jones</b>  |                       | TITLE (SPECIFY)<br><b>Deputy</b>  |  | MEDICAL EXAMINER<br>DATE SIGNED <b>11-28-86</b>   |                               |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>William P. Jones, MD</b>  |                       | ADDRESS<br><b>695 America Ct. 21035</b>   |  |   |                               |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |                       | 23b. DATE<br><b>11-29-86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview PK.</b>   |                               |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Baltimore</b>  |                       | COUNTY<br><b>md.</b>  |  | STATE   |                               |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>T. A. Haederty</b>  |                       | ADDRESS<br><b>Annapolis Md. 21401</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 2 1986</b>  |                               |
| 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |                       |   |  |   |                               |

DIVISION OF VITAL RECORDS, 301 W. PRINCE ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PLACE OF ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT SLIP. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRINCE STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 11  
(VR A15 ME (5))

022001-303

—



*[Faint, mostly illegible text and markings are visible throughout the page, including what appears to be a date '11-22-54' in the upper left and various handwritten notes.]*



025379 NOV 29 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |                            |   |   |
|--|--|---|--|---|----------------------------|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>William J.J. Huntley</i>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>11/20/86</i> |   | 2b. HOUR<br><i>1235 AM</i> |   |   |
| 3. SEX<br><i>Male</i>  |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>2/20/16</i>  |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>70</i><br>YRS MONTHS DAYS   |   |
| 7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY)<br><i>New York</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>ANNE Arundel County MD.</i>  |   |
| 10. CITY OR TOWN OF DEATH<br><i>Shady side</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>4947 Chestnut St.</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>retired</i>  |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>US Gov.</i>   |   |
| 13a. STATE<br><i>Md.</i>   |  | 13b. COUNTY<br><i>AACo.</i>   |  | 13c. CITY OR TOWN<br><i>Sady Side</i>   |                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |   |
| 13e. STREET ADDRESS / ZIP CODE<br><i>4947 Chestnut ST. 20764</i>   |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>William George Huntley</i>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Margareth Ann Barlow</i>  |                            |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>Yes</i>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>WWII 577097383</i>  |  | 17. INFORMANT<br>ADDRESS<br><i>Arlene E. Huntley Same as #13</i>  |                            |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Colonic carcinoma</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>—</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>—</i><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <i>—</i> |  |   |  |   |                            |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><i>7 mos</i> |
| 19a. DATE OF OPERATION<br><i>—</i>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>—</i>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                            | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>— 19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><i>—</i>  |                            |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><i>—</i>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><i>— — — —</i>   |                            | 21g. DATE SIGNED<br><i>11/21/86</i>   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>6/30/86</i> , 19 <i>—</i> , to <i>11/20/86</i> , 19 <i>—</i> , that (I) (we) last saw the deceased alive on <i>10/20</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                             |  |   |  |   |                            |   | 22c. DATE SIGNED<br><i>11/21/86</i>                             |
| 22b. SIGNATURE<br><i>Stuart E. Selonick, M.D.</i>  |  | 22c. DEGREE<br><i>—</i>   |  | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>             |                            | 22e. ADDRESS<br><i>51 Franklin St. Annapolis, Md.</i>   |   |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Stuart E. Selonick, M.D.</i>   |  | 22g. ADDRESS<br><i>51 Franklin St. Annapolis, Md.</i>   |  | 22h. DATE SIGNED<br><i>NOV 26 1986</i>  |                            | 22i. REGISTRAR'S SIGNATURE<br><i>Julia Gordon-Randall</i>   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>11-22-86</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Md. Veterans</i>   |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Crownsville AACo. Md.</i>  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Hardesty Funeral Home Annapolis. Md.</i>  |  |   |  | 25. DATE REC'D. BY REGISTRAR<br><i>NOV 26 1986</i>  |                            |   |   |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

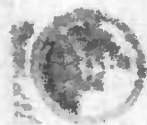
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medicolegal death must be reported to the State Department of Health and Mental Hygiene.

MEDICAL CERTIFICATION



0222100 2002



0 25 184 NOV 25 86

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

EST

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>PAN SAK HWANG</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 23, 1986</b>  |  | 2b. HOUR<br><b>455 AM</b>  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Oriental</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 15, 1910</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS   | IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Korea</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Korea</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>                                  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Business Manager</b>                         |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>A A Co.</b>   | 13c. CITY OR TOWN<br><b>Glen Burnie</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Yoon Hum</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>(Unknown)</b>                                       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No NA</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213.90.1530</b>  | 17. INFORMANT<br>ADDRESS<br><b>(Brother-In-Law) 5460 Park Heights<br/>Mr. Jon Kwon Balto. Md. 21025</b> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Cancer from Gall bladder</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Gastrointestinal bleed</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)        |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/16</b> 19 <b>86</b> to <b>11/23</b> 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>11/23</b> 19 <b>86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                  |  |   |   |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>11/22/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>YEONG H. CHOI, M.D.</b>  |  | 22e. ADDRESS<br><b>1412 CRAIN HIGHWAY, NORTH UNIT 6A<br/>GLEN BURNIE, MARYLAND 21061</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>Nov 25, 1986</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Cem.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Padonia Balt. Md.</b>               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>H. A. Hupshier</b><br><b>Singleton Funeral Home Glen Burnie, Maryland</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 25 1986</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                     |  |

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked as (a) or (b) showing any injury, or other traumatic event, the medical examiner must be notified of one.

THE  
STATE OF  
NEW YORK  
IN SENATE  
JANUARY 10, 1907.  
REPORT  
OF THE  
COMMISSIONERS OF THE  
LAND OFFICE  
IN RESPONSE TO A  
RESOLUTION PASSED  
BY THE SENATE  
MAY 1, 1906.  
ALBANY:  
J. B. LEECH, JR.,  
PRINTERS.  
1907.

COTTON

025457 DEC 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

30

570

REG. NO.

|  |  |   |   |   |   |  |  |  |  |   |  |  |   |  |  |  |  |   |                                     |
|--|--|---|---|---|---|--|--|--|--|---|--|--|---|--|--|--|--|---|-------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Leonard C. JAGGS</i>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>Nov 20 86</i> |   |   | 2b. HOUR<br><i>11:10 PM</i>  |  |  |  |   |  |  |   |  |  |  |  |   |                                     |
| 3. SEX<br><i>MALE</i>  |  | 4. RACE<br><i>WHITE</i>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>3/27/22</i>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>64</i> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |   |  |  |   |  |  |  |  |   |                                     |
| 7a. BIRTHPLACE (STATE OF FOREIGN COUNTRY)<br><i>England</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>ANNE ARUNDEL</i> MD.  |  |  |  |   |  |  |   |  |  |  |  |   |                                     |
| 10. CITY OR TOWN OF DEATH<br><i>Annapolis</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Anne Arundel General Hosp</i> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Retired</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Machinist</i>            |  |   |  |  |   |  |  |  |  |   |                                     |
| 13a. STATE<br><i>MD.</i>   |  |   | 13b. CITY OR TOWN<br><i>Hanover</i>                     |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><i>7230 Forrest Ave. 21076</i>     |  |  |   |  |  |   |  |  |  |  |   |                                     |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>unknown</i>   |  |   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>unknown</i>                                 |  |  |  |  |   |  |  |   |  |  |  |  |   |                                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>no</i>  |  |   | 16b. SOCIAL SECURITY NO.<br><i>186-34-6471</i>          |   | 17. INFORMANT<br>ADDRESS<br><i>Mike Benning same as 13e</i>                                     |  |  |  |  |   |  |  |   |  |  |  |  |   |                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>oat cell CA of lung</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____ |  |   |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>8 mos</i>     |  |   |  |  |   |  |  |  |  |   |                                     |
| MEDICAL CERTIFICATION  |  |   |   |   |   |  |  |  |  |   |  |  |   |  |  |  |  |   |                                     |
|  |  |   |   |   |   |  |  |  |  | 19a. DATE OF OPERATION<br>_____   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>_____                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                     |
|  |  |   |   |   |   |  |  |  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. _____ 19____            |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br>_____ |  |   |                                     |
|  |  |   |   |   |   |  |  |  |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>_____ |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>_____ 11/20/86 _____              |  |   |                                     |
|  |  |   |   |   |   |  |  |  |  | 22a. I certify that (I) (this hospital) attended the deceased from <i>3/5/86</i> , 19____, to <i>11/20/86</i> , 19____, that (I) (we) lost saw the deceased alive on <i>11/20/86</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |  |  |   | 22c. DATE SIGNED<br><i>11/21/86</i> |
| 22b. SIGNATURE<br><i>Stuart E. Selouch, M.D.</i>   |  |   |   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>11/21/86</i>                              |  |   |  |  |   |  |  |  |  |   |                                     |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Stuart E. Selouch, M.D.</i>  |  |   |   |   |   | 22e. ADDRESS<br><i>51 Franklin St Annapolis Md 21014</i>   |  |  |  |   |  |  |   |  |  |  |  |   |                                     |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Cremation</i>   |  |   | 23b. DATE<br><i>11/23/86</i>                            |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Balto.Wash.Crematory</i>                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Laurel P.G. Md.</i> |  |  |   |  |  |   |  |  |  |  |   |                                     |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>7601 Sandy Spring Rd. Fleck Funeral Home, Inc. Laurel, Md.</i>  |  |   |   |   |   | 25. DATE REC'D BY REGISTRAR<br><i>NOV 28 1986</i>  |  |  |  |   |  |  |   |  |  |  |  |   |                                     |
|  |  |   |   |   |   | 26. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |  |  |   |  |  |   |  |  |  |  |   |                                     |

20% COTTON  
MADE IN  
CHINA



032425 REC-103

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please cremate carbon copiers, pages 1 and 2, and certify within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, then

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |  |  |  |  | 88 30371   |  |   |  |   |  |
|--|--|--|--|--|--|--|--|--|--|--|--|---|--|---|--|
| WESTBROOK  |  |  |  |  |  |  |  |  |  | REG. NO.   |  |   |  |   |  |
| DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  |  |  |  |  |  |  | DATE OF DEATH                                    |  | HOUR  |  |   |  |
| ERMA W JAMES   |  |  |  |  |  |  |  |  |  | 11 16 86   |  | 145 M   |  |   |  |
| SEX  |  |  |  |  |  |  |  |  |  | AGE  |  | IF UNDER 1 YEAR                                       |  | IF UNDER 24 HRS   |  |
| FE   |  |  |  |  |  |  |  |  |  | 89   |  | MONTHS  |  | DAYS  |  |
| BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  |  |  |  |  |  |  |  | CITIZEN OF WHAT COUNTRY?                         |  | DATE OF BIRTH   |  | MARRIED   |  |
| Georgia  |  |  |  |  |  |  |  |  |  | U.S.A.   |  | Aug 23 1897   |  | X NEVER MARRIED   |  |
| CITY OR TOWN OF DEATH  |  |  |  |  |  |  |  |  |  | BALTIMORE CITY OR COUNTY OF DEATH                |  | WIDOWED   |  | DIVORCED  |  |
| Annapolis  |  |  |  |  |  |  |  |  |  | ANNE ARUNDEL                                     |  | MD  |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  |  |  |  |  |  | USUAL OCCUPATION                                 |  | KIND OF BUSINESS OR INDUSTRY                          |  |   |  |
| 13a. STATE   |  |  |  |  |  |  |  |  |  | 13b. COUNTY                                      |  | 13c. CITY OR TOWN                                     |  | 13d. INSIDE CITY LIMITS?  |  |
| Md   |  |  |  |  |  |  |  |  |  | A.A.   |  | Arnold  |  | YES X NO  |  |
| FATHER'S NAME  |  |  |  |  |  |  |  |  |  | MOTHER'S MAIDEN NAME                             |  | STREET ADDRESS / ZIP CODE                             |  |   |  |
| Subius O. Westbrook  |  |  |  |  |  |  |  |  |  | HATTIE ROLAND                                    |  | 200 VIA DANTE Rd 21012                                |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.                         |  | 17. INFORMANT   |  | ADDRESS   |  |
| NO   |  |  |  |  |  |  |  |  |  | 220-36-8076                                      |  | IDA ROGERS  |  | 205 VIA DANTE Rd  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)        |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |  |   |  |   |  |
| Pneumonia  |  |  |  |  |  |  |  |  |  | 24 hours   |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                    |  |  |  |  |  |  |  |  |  | (b)  |  | DUE TO, OR AS A CONSEQUENCE OF                        |  | (c)   |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: |  |  |  |  |  |  |  |  |  |  |  |   |  |   |  |
| Multiple strokes - Senile dementia   |  |  |  |  |  |  |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                                |  |
|  |  |  |  |  |  |  |  |  |  |  |  | YES NO X  |  | YES NO  |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY                              |  | 21c. HOW INJURY OCCURRED                              |  |   |  |
|  |  |  |  |  |  |  |  |  |  | HOUR A.M. MONTH DAY YEAR                         |  | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY                             |  | 21f. LOCATION   |  |   |  |
| WHITE AT WORK NOT WHILE AT WORK  |  |  |  |  |  |  |  |  |  | (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)    |  | STREET CITY OR TOWN COUNTY STATE                      |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from  |  |  |  |  |  |  |  |  |  | 11/15 1986                                       |  | 11/16 1986  |  | that (I) (we) last saw the deceased alive on  |  |
|  |  |  |  |  |  |  |  |  |  | 11/16 1986                                       |  |   |  | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated |  |
| 22b. SIGNATURE   |  |  |  |  |  |  |  |  |  | DEGREE   |  | 22c. DATE SIGNED                                      |  |   |  |
| Richard N Keeler MD  |  |  |  |  |  |  |  |  |  |  |  | 11/16/86  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS                                     |  |   |  |   |  |
| Richard N Keeler MD  |  |  |  |  |  |  |  |  |  | 51 FRANKLIN ST ANNAPOLIS, MD                     |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  |  |  |  |  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                    |  | 23d. LOCATION   |  |
| Burial   |  |  |  |  |  |  |  |  |  | 11-19-1986                                       |  | Md Veterans   |  | Crownsville A.A. Md   |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |  |  |  |  | ADDRESS  |  | DATE REC'D. BY REGISTRAR                              |  | REGISTRAR'S SIGNATURE   |  |
| C.E. Hicks   |  |  |  |  |  |  |  |  |  | 1922 Forest Drive                                |  | NOV 9 1986  |  | Julia Davidson-Randall  |  |



2nd April 1942

© 1994 by the Board of Trustees of the University of Illinois

19. 10. 1954

[illegible]

2007-01-01 1291-41-11

2000-2001



024754 NOV 21 1987

Item # 5, Film G 623, 12/13/87 ra

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 30372

REG. NO.

|  |   |  |  |  |   |
|--|---|--|--|--|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Stanley Louis Jastremski   |   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>November 18, 1986                            |  | 2b HOUR<br>A M  |
| 3 SEX<br>Male  | 4 RACE<br>White   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>August 20, 1920   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b CITIZEN OF WHAT COUNTRY?<br>USA  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel Co. MD.                                    |   |
| 10 CITY OR TOWN OF DEATH<br>Glen Burnie  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>104 Sandsbury Ave. |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Fuel Oil Dealer | 12b KIND OF BUSINESS OR INDUSTRY<br>Self-Employed  |   |
| 13a STATE<br>Maryland  |   | 13b COUNTY<br>A A Co.  | 13c CITY OR TOWN<br>Glen Burnie  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Michael Jastremski  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Agnes Bawroski   |  |  |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>NA  | 17 INFORMANT (Brother)<br>Edward C. Jestremski   |  | ADDRESS<br>Same As #13   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>V-fib</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>CHDx. CT, Cardiac Angioma</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>16 months</u>   |
| 19a DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/18/85</u> to <u>9/18/86</u> , that (I) (we) last saw the deceased alive on <u>9/18/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |  |  |  |   |
| 22b. SIGNATURE<br><u>David A. Schwartz</u>   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  | 22c. DATE SIGNED<br><u>11/19/86</u>  |   |
| 22d. PHYSICIAN'S NAME (WITH ADDRESS)<br>David A. Schwartz, D. O.   |   | 22e. ADDRESS<br>Suite 200 7845 oakwood rd. Glen Burnie Maryland 21061 760-5463   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>Nov 21, 1986   | 23c. NAME OF CEMETERY OR CREMATOR<br>Holy Cross Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brooklyn A A Co. Md.                             |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Singleton Funeral Home   |   | ADDRESS<br>Glen Burnie, Maryland   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 20 1986   | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card Pages 1 and 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, a medical examiner must be notified by the funeral director.

05 MAY 24 1951 13

*[Faint, illegible handwriting on lined paper]*

28-544-25-4/5

*[Faint, illegible handwriting]*

025069 NOV 25 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please move captioned papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8630373

REG. NO.

|   |  |   |  |   |   |   |
|---|--|---|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOHN T. JENKINS</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 21, 1986</b>    |   | 2b. HOUR<br><b>9:50 PM</b>              |   |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>SEPTEMBER 10, 1899</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL Co. MD.</b> |
| 10. CITY OR TOWN OF DEATH<br><b>SEVERNA PARK</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERIDIAN NURSING CTR.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Produce Salesman</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Super Market</b>            |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>A.A.</b>   |   | 13c. CITY OR TOWN<br><b>Glen Burnie</b> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William W. Jenkins</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ella Evans</b> |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216-32-9922</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Anna E. Jenkins Same as 13c</b>  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>ARTHROSCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |   |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY OFFICE FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |
| 22a. I certify that (1) this (hospital) attended the deceased from <b>8/17</b> , 19 <b>86</b> , to <b>9/21</b> , 19 <b>86</b> , that (1) I saw the deceased alive on <b>11/13</b> , 19 <b>86</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (1) I did not view the body after death.                  |  |   |  |   |   |   |
| 22b. SIGNATURE<br><b>John Shaums</b>  |  | DEGREE<br><b>PHYSICIAN</b>  |  | 22c. DATE SIGNED<br><b>11/23/86</b>   |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN SHAUMS</b>   |  | 22e. ADDRESS<br><b>518 CAMP MANN RD. LINTHICUM, MD</b>  |  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/24/86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross Cemetery</b>  |   |   |
| 23d. LOCATION (CITY OR TOWN)<br><b>Baltimore</b>  |  | COUNTY<br><b>A.A.</b>   |  | STATE<br><b>Maryland</b>  |   |   |
| 24. FUNERAL DIRECTOR<br><b>George J. Gonce 4001 Ritchie Hwy Balto Md</b>  |  |   |  | 25a. DATE REC'D BY REGISTRAR<br><b>NOV 24 1986</b>  |   |   |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia D. ...</b>   |   |   |

BP

234 *Journal of Management Inquiry* 16(2)

444

24643 NOV 20 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 0 3 0 3 7 4

|   |  |   |  |   |                                   |   |   |   |   |  |
|---|--|---|--|---|-----------------------------------|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Ethel C. Johanson  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 9, 1986      |   |                                   | 2b. HOUR<br>M   |   |   |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11/27/1916  |                                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS                                     |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel County, MD.              |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Glen Burnie  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>North Arundel Hospital |  |   |                                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Domestic                   |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland |  |   | 13b. COUNTY<br>A.A. Co.                                      |   | 13c. CITY OR TOWN<br>Millersville |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Endley  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Hadley |   |                                   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no    |   |   | 16b. SOCIAL SECURITY NO.<br>217-03-0483 |  |
| 17. INFORMANT<br>ADDRESS<br>Mrs. Helen R. Hoover Same as #13  |  |   |  |   |                                   |   |   |   |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac - Pulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

Multiple Myeloma

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

One day

6 mos

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from July 19, 1986, to Nov 9, 1986, that (I) (we) last saw the deceased alive on Nov 19, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

Dr. Philip H. Konits, MD.

606 Hammonds Lane, Balto., Md. 21225

|  |  |                       |  |   |  |  |  |
|--|--|-----------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                         |  | 23b. DATE<br>11/12/86 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem Pk |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie, A.A. Co., Md. |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>McCully Funeral Homes Balto. Md. 21225 |  |                       |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 18 1986            |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall                     |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation conducted.)

MEDICAL CERTIFICATION





2337 NOV 10 1986

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |                       |  |  |   |  |   |   |  |
|--|-----------------------|--|--|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Edward F. Johnson</b>   |                       |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11 1 1986</b> |   |  | 2b. HOUR <b>AM</b>  |   |  |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>Car</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>11 18 33</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>52</b> YRS.  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   | IF UNDER 24 HRS.<br>HOURS MIN  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>11 1 1986</b>                         | 2d. HOUR <b>1906</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW YORK</b>   |                       | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>AA</b> MD.                               |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>  |                       | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HANE Arnold Gen</b> |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Banking</b>          |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Senior VP</b>                 |  |
| 13a. STATE<br><b>VA.</b>   |                       |  | 13b. COUNTY<br><b>Arlington</b>  | 13c. CITY OR TOWN<br><b>Arlington</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     | 13e. STREET ADDRESS<br><b>2102 N. Military</b>                                      |   |  |
| FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>EDWARD F. JOHNSON, Sr.</b>  |                       |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>HELEN (unknown)</b>   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>  |                       |  | 16b. SOCIAL SECURITY NO.<br><b>Korea 050-26-7122</b>   |   | 17. INFORMANT<br><b>2102 N. Military Rd. 22207 Patricia C. Johnson, (wife) Arlington</b> |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <b>A.S.C.U.D.</b><br>(b) <b>A.S.C.U.D.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <b>VA</b> |                       |  |  |   |  |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |                       |  |  |   |  |   |   |  |
| 19a. DATE OF OPERATION   |                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)            |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                       |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                       |  |  |   |  |   |   |  |
| ACTUAL SIGNATURE<br><b>William P. Jones</b> MD   |                       |  | TITLE (SPECIFY)<br><b>M.D. Deputy</b>  |   |  | DATE SIGNED<br><b>11/2/86</b>   |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>William P. Jones, M.D.</b>   |                       |  | ADDRESS<br><b>695 America Crt. Davidsonville, Md. 21035</b>  |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>  |                       |  | 23b. DATE<br><b>11/2/86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lee Crematory</b>                               |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Washington, D.C.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>MURPHY FUNERAL HOME, INC.</b>   |                       |  |  |   | 25a. DATE REC'D BY REGISTRAR<br><b>NOV 05 1986</b>                                       |   |   |  |
| 24b. ADDRESS<br><b>4510 Wilson Blvd. Arlington, VA 22203</b>   |                       |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia T. ...</b>  |   |   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION



2332 NOV 19 32

Summit Pt. 10000 ft. 10000 ft.

Oct 11 1932 10000 ft. 10000 ft.

10000 ft.

10000 ft. 10000 ft. 10000 ft.

10000 ft. 10000 ft. 10000 ft.

10000 ft. 10000 ft. 10000 ft.

10000 ft. 10000 ft. 10000 ft.

10000 ft. 10000 ft. 10000 ft.

10000 ft. 10000 ft. 10000 ft.

10000 ft. 10000 ft. 10000 ft.

10000 ft. 10000 ft. 10000 ft.

10000 ft. 10000 ft. 10000 ft.

10000 ft. 10000 ft. 10000 ft.

10000 ft. 10000 ft. 10000 ft.

10000 ft. 10000 ft. 10000 ft.

10000 ft. 10000 ft. 10000 ft.

10000 ft. 10000 ft. 10000 ft.

10000 ft. 10000 ft. 10000 ft.

023926 NOV 14 86

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 30370  
EST  
REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ELLA IRENE JOHNSON</b>                            |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 08, 1986</b>                                    |  | 2b. HOUR<br><b>450 PM</b>  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>January 15, 1901</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY</b> MD.               |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                 |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                       |  |   |   |  |  |
| 13a. STATE<br><b>Maryland</b>   | 13b. COUNTY<br><b>Anne Arundel</b>   | 13c. CITY OR TOWN<br><b>Glen Burnie</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>903 Broadview Blvd. 21061</b>                   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>William Ridgley</b>   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Emma Hungerford</b>                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br><b>218-18-9317D</b>   |   | 17. INFORMANT ADDRESS<br><b>Mary L. Fedeli Same as # 13</b>                          |  |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*Pneumonia*APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH*4 hours*Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

*Congestive Heart Failure**5 years*

DUE TO, OR AS A CONSEQUENCE OF

(c)

*Arteriosclerotic Cardiovascular Disease**5 years*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

## MEDICAL CERTIFICATION

|   |  |  |  |  |   |
|---|--|--|--|--|---|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <i>84</i> to <i>Nov 8</i> 19 <i>86</i> , that (I) (we) last<br>saw the deceased alive on <i>October 21</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did not) view the body after death. |  |  |  |  |   |
| 22b. SIGNATURE<br><i>elliott gorbaty</i>  |  | DEGREE   |  | 22c. DATE SIGNED<br><i>11/09/86</i>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ELLIOTT GORBATY, M.D.</b>   |  | 22e. ADDRESS<br><b>7845 OAKWOOD ROAD<br/>GLEN BURNIE, MD. 21061</b>    |  |  |   |

|   |                              |  |   |
|---|------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>11/12/86</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Jennings Chapel Cemetery</b>  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Florance Howard Maryland</b> |
| 24. FUNERAL DIRECTOR<br><b>Leory M. &amp; Russell C. Witzke</b> |                              | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>NOV 12 1986</b> <i>Julia Decker-Rodriguez</i> |   |
| 1630 Edmondson Avenue, Catonsville, MD. 21228                   |                              |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove certificates 1 and 2 and file with the funeral director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified orally.

153038 001010

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

1900

1

20% COTTON FIELD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

EST

|  |  |  |   |   |  |  |  |
|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LESTER F JOHNSON</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 5, 1986</b> |   |  | 2b. HOUR<br><b>1238 AM</b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>white</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 6, 1908</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Truck Driver</b>                                    |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Freight</b>  |  |  |   |   |  |  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>A.A.</b>   |   | 13c. CITY OR TOWN<br><b>Glen Burnie</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 13e. STREET ADDRESS / ZIP CODE<br><b>887 S. Shore Dr. (21061)</b>  |  |  |   |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Johnson</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Addie</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217-07-8133</b>   |   | 17. INFORMANT ADDRESS<br><b>Burnie, Md. 21061</b><br><b>Albert W. Herb, Jr., 889 S. Shore Dr., Glen</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Confessive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>Oct. 27 1986 P.M.</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct. 27 1986</b> to <b>Nov. 5 1986</b> , that (I) (we) last saw the deceased alive on <b>Nov. 4 1986</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.         |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Charles J. Wil, M.D.</b>  |  | DEGREE   |   | 22c. DATE SIGNED<br><b>Nov. 5, 1986</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME<br><b>CHARLES J. WIL, M.D.</b>   |  | 22e. ADDRESS<br><b>7845 OAKWOOD ROAD, SUITE 204 GLEN BURNIE, MARYLAND 21061</b>  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/7/86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Good Shepherd Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Ellicott City, Howard Co. MD</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>George J. Gonce, 4001 Ritche Hwy., Baltimore, MD (21225)</b>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV - 7 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |

BP

20% COTTON FIBER

CELESTINE

02344 101002

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return it to the funeral home. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  | REG. NO.                                     |  |
|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Bernard F. Jones  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 12 1986                              |  |  | 2b. HOUR<br>11:20 PM   |  |  |  |
| 3 SEX<br>Male   |  | 4 RACE<br>C 1  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 5 22  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Washington, D.C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel MD.                              |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Annapolis   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Anne Arundel General Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sales Manager    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Self-Employed   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Worcester 13c. CITY OR TOWN Ocean City   |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>9004 Caribbean Drive 21842 |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jesse Jones   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Marie Able                          |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>yes   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>W.W. II 578-16-7284   |  | 17 INFORMANT<br>ADDRESS<br>Dorothy Jones wife same as #13   |  |  |  |  |  |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute Respiratory Failure<br>DUE TO, OR AS A CONSEQUENCE OF (b) Severe Pulmonary Fibrosis<br>DUE TO, OR AS A CONSEQUENCE OF (c) Bronchogenic Carcinoma<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>Diabetes mellitus Type II; Peripheral Vascular Disease; Stasis ulcer  |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-6, 19 86, to 11-12, 19 86, that (I) (we) last saw the deceased alive on 11-12, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Villamor S. Reyes M.D.  |  |  |  |   | DEGREE<br>M.D.   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>11-12-86                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>VILLAMOR S. REYES, M.D.  |  |  |  |   | 22e. ADDRESS<br>951 Central Ave. East Odgewater MD                                   |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  | 23b. DATE<br>Nov 15 86   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Maryland Veterans Cem.                         |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cheltenham Prince Georges Md.  |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME Francis J. Collins, Jr.<br>ADDRESS 500 University Blvd. West, Silver Spring, Md.  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 21 1986   |  | 25b. REGISTRAR'S SIGNATURE<br>John Gordon-Randall            |  |  |  |  |

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose this page with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   | REG. NO.  |  |
|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>John M. Kempton  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov. 30, 1986                        |   | 2b. HOUR<br>M  |
| 3. SEX<br>Male  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 11, 1915   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>11 YRS.                                  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Montana  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel MD.                    |   |  |
| 10. CITY OR TOWN OF DEATH<br>Annapolis  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Anne Arundel General Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Civil Service               |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD  |  | 13b. COUNTY<br>AA   | 13c. CITY OR TOWN<br>Arnold   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Bernice E. Kempton  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Martha Magnuson  |   | 13e. STREET ADDRESS / ZIP CODE<br>516 St. Andrews Road Hill 21012                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR DATES)<br>1WW II 557-12-0933  |   | 17. INFORMANT<br>Audrey A. Kempton. Same as #13   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac arrest.<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on 11/26/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |   |   |   |  |
| 22b. SIGNATURE<br>H.D. Goldstein, M.D.  |  | DEGREE  |   | 22c. DATE SIGNED<br>12/1/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>H.D. GOLDSTEIN, M.D.   |  | 22e. ADDRESS<br>205 Ridgely Ave. Annapolis, MD  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>Dec. 3, 1986   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Maryland Veterans   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Crownsville AA MD   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 3 1986   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Taylor Funeral Chapel - Annapolis, MD   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Gordon-Rubio  |   |   |  |

BP

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*



*[Faint handwritten text at the bottom of the page, possibly a signature or date.]*

024214 NOV 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, follow in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as below.

FOR  
STATE  
REGISTRAR
 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

EDT

|   |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |
|---|--|--|---|--|--|---|--|--|--|--|--|--|--|--|---|--|--|---|--|--|---|--|--|
| 1. BASED NAME<br>(PRINT) <b>RUTH</b>  |  |  | FIRST <b>LENORE</b>   |  |  | MIDDLE <b>KENDALL</b>   |  |  | LAST   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 12, 1986</b>   |  |  | 2b. HOUR<br><b>1115 AM</b>  |  |  |   |  |  |   |  |  |
| 3. SEX<br><b>Female</b>   |  |  | 4. RACE<br><b>white</b>   |  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Oct. 12, 1915</b>   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b>   |  |  | IF UNDER 1 YEAR MONTHS DAYS  |  |  | IF UNDER 24 HRS HOURS MIN.  |  |  |   |  |  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Kent Co. Md.</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY</b> MD.               |  |  |  |  |  |   |  |  |   |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NORTH FAC. AD. HOSP. ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |  |  |   |  |  |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>                                       |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |   |  |  |   |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |  |   |  |  |   |  |  | 13b. COUNTY<br><b>Kent</b>   |  |  | 13c. CITY OR TOWN<br><b>Rock Hall</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>RFD Piney Neck 21661</b> |  |  |   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Nelson Williams</b>   |  |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Annie Downey</b>   |  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>   |  |  |   |  |  | 16b. SOCIAL SECURITY NO.<br><b>218 16 9745</b>                |  |  | 17. INFORMANT ADDRESS<br><b>Joseph Kendall Rock Hall, Md. 21661</b> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CH of lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Severe COPD</b>   |  |  |   |  |  |   |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hours</b><br><b>1 yr.</b>                 |  |  |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Severe COPD</b>   |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |   |  |  |   |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/12</b> to <b>11/12</b> 19 <b>86</b> that (I) (we) lost<br>saw the deceased alive on <b>11/12</b> 19 <b>86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>David A Schwartz</b> DEGREE  |  |  |   |  |  |   |  |  |  |  |  |  |  |  | 22c. DATE SIGNED<br><b>11/12/86</b>   |  |  |   |  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DAVID A SCHWARTZ, M.D.</b>  |  |  |   |  |  |   |  |  | 22e. ADDRESS<br><b>7845 OAKWOOD RD, SUITE 200<br/>GLEN BURNIE, MD 21061</b>          |  |  |  |  |  |   |  |  |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  |  | 23b. DATE<br><b>11/15/86</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Wesley Chapel Cem</b>  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Rock Hall, Md.</b>                  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>(NAME) <b>J. Willis Wells</b><br>ADDRESS <b>Chestertown, Md.</b>  |  |  |   |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 17 1986</b>                                  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |  |   |  |  |   |  |  |   |  |  |

BP

034311 10 32

MEMORANDUM FOR THE ASSISTANT ATTORNEY GENERAL

MEMORANDUM FOR THE ASSISTANT ATTORNEY GENERAL

CLERK OF THE DISTRICT COURT

RE: [illegible]  
[illegible]

1000 0000

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the Court at the City of New York, this 10th day of November, 1900.

NOV 13 1900

CLERK OF THE DISTRICT COURT

025692 DEC 2 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |   |
|---|--|---|--|---|--|--|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>FRANCES E. KESS</b>  |  |   |  |   |  |  |  |   |   |
| 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 21, 1986</b>  |  | 2b. HOUR<br><b>2:15</b> M   |  |   |  |  |  |   |   |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>APRIL 9 1930</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS.  |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>                       |  |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NURSE (L.P.N.)</b>       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MEDICAL</b>   |   |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>A.A.</b>  |  | 13c. CITY OR TOWN<br><b>GLEN BURNIE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>228 HOLLYWOOD CT 21061</b>   |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>WILLIAM E. HANDY</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>LAUREL ELLEN DASHIELDS HANDY</b>   |  |  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>UNK</b>  |  | 17. INFORMANT ADDRESS<br><b>RALPH F. KESS 228 HOLLYWOOD CT GLEN BURNIE</b>  |  |  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Ovarian Cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.       |  |   |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 year</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |  |   |  |  |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-25</b> , 19 <b>86</b> , to <b>11-21</b> , 19 <b>86</b> , that (I) (we) lost the deceased above on <b>11-21</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |   |   |
| 22b. SIGNATURE<br><b>Long S. Hsu</b>  |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>11-21-86</b>  |  |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LONG S. HSU, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>7845 OAKWOOD ROAD #205 GLEN BURNIE, MARYLAND 21061</b>   |  |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>11/25/86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CHURCH CEMETERY</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>TYASKIN MD</b>                                 |  |   |   |
| 24. FUNERAL DIRECTOR NAME<br><b>J.B. JENKINS F.H.</b>   |  |   |  | ADDRESS<br><b>7474 LANDOVER RD LANDOVER MD</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 28 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Lisa Fisher-Rudner</b>   |   |

BP \_\_\_\_\_

032823 100 502



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/B4  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8530382

REG. NO.

|  |           |   |                                 |   |  |
|--|-----------|---|---------------------------------|---|--|
| 1. FOR STATE REGISTRAR   |           | 2a. DATE OF DEATH   |                                 | 2b. HOUR  |  |
| DECEASED NAME<br>(TYPE OR PRINT)   |           | MONTH DAY YEAR  |                                 | M   |  |
| Henry G. Klenke  |           | 11-12-86  |                                 | 5:45  |  |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR   |  |
| male   | caucasian | MONTH DAY YEAR  | 71                              | MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |           | 7b. CITIZEN OF WHAT COUNTRY?  |                                 | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| New York   |           | United States   |                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| 10. CITY OR TOWN OF DEATH  |           | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| Annapolis  |           | Anne Arundel General Hospital   |                                 | Supervisor  |  |
| 13a. STATE   |           | 13b. COUNTY   |                                 | 13c. CITY OR TOWN   |  |
| Maryland   |           | Anne Arundel  |                                 | Annapolis   |  |
| 14. FATHER'S NAME  |           | 15. MOTHER'S MAIDEN NAME  |                                 | 13d. STREET ADDRESS / ZIP CODE  |  |
| FIRST MIDDLE LAST  |           | FIRST MIDDLE LAST   |                                 | 130 Hearne Road/21401   |  |
| Henry G. Klenke  |           | Pauline Lehre   |                                 |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |           | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |                                 | 17. INFORMANT ADDRESS   |  |
| no   |           | 320-10-6998A  |                                 | June L. Klenke (wife) see #13   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>multiple skin ulcers</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Shy-DRAGER Syndrome</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>none</u> |           |   |                                 |   |  |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |           |   |                                 |   |  |
| MEDICAL CERTIFICATION  |           |   |                                 |   |  |
| 19a. DATE OF OPERATION   |           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                 | 20e. AUTOPSY?   |  |
|  |           |   |                                 | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
|  |           | P.M. 19   |                                 |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                                 | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
|  |           |   |                                 | STREET  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/20</u> 19 <u>81</u> to <u>11-12</u> 19 <u>86</u> , that (I) (we) lost<br>saw the deceased alive on <u>11-11</u> 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |           |   |                                 |   |  |
| 22b. SIGNATURE   |           | DEGREE  |                                 | 22c. DATE SIGNED  |  |
| THOMAS WALSH M.D.  |           |   |                                 | 11-13-86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |           | 22e. ADDRESS  |                                 |   |  |
| THOMAS WALSH M.D.  |           | 780 Ritchie Hwy Severna Park Md 21146   |                                 |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |           | 23b. DATE   |                                 | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| Burial   |           | Nov. 15, 1986   |                                 | Parklawn Memorial Park  |  |
|  |           |   |                                 | CITY OR TOWN COUNTY STATE   |  |
|  |           |   |                                 | Rockville Maryland  |  |
| 24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, PA<br>NAME ADDRESS  |           | 25a. DATE REC'D. BY REGISTRAR   |                                 | 25b. REGISTRAR'S SIGNATURE  |  |
| 7557 Wisconsin Av., Bethesda, Md. 20814  |           | NOV 17 1986   |                                 | John T. ...   |  |

BP



054215 1012

11-22-22 22

V. 101111

11 13 14

11-22-22

11-22-22 11-22-22

11-22-22

11-22-22 11-22-22

11-22-22

11-22-22

11-22-22

11-22-22 11-22-22

11-22-22 11-22-22

11-22-22 11-22-22

11-22-22 11-22-22

11-22-22 11-22-22

11-22-22 11-22-22

11-22-22 11-22-22

11-22-22 11-22-22

11-22-22 11-22-22

11-22-22 11-22-22

11-22-22 11-22-22

24582 NOV 20 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |   |                           |  |
|--|--|---|---|---|---------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Daisy B. Klock</b>   |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 11 86</b>                     |   | 2b HOUR<br><b>4:50 PM</b> |  |
| 3 SEX<br><b>FEMALE</b>   |  | 4 RACE<br><b>WHITE</b>  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 17<sup>th</sup> 1895</b>  |                           |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |   | IF UNDER 24 HRS.<br>HOURS MIN.  |                           |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington DC</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                           |  |
| 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNA ARUNDEL</b> MD  |  |   |   |   |                           |  |
| 10 CITY OR TOWN OF DEATH<br><b>Crofton</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Crofton Convalescent Center</b> |   | 12a USUAL OCCUPATION<br>(TYPE OR WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |                           |  |
| 12b KIND OF BUSINESS OR<br><b>Own Home</b>   |  |   |   |   |                           |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |   |   |                           |  |
| 13a STATE<br><b>MARYLAND</b>   |  | 13b COUNTY<br><b>Anne Arundel</b>   |   | 13c CITY OR TOWN<br><b>Crofton</b>  |                           |  |
| 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e STREET ADDRESS / ZIP CODE<br><b>204 Marley NECK Road 21114</b>  |   |   |                           |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jesse M. Gallahan</b>  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Florence E. Nothey</b> |   |                           |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>579-62-5612</b>  |   | 17 INFORMANT<br>ADDRESS<br><b>LINDA SHIPP SAME AS #13</b>   |                           |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRAIN ANOXIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cardio Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Bilateral Pleural Effusions</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>(?) 5 minutes<br>(?) 5 minutes<br>24 hours |  |   |   |   |                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.<br><b>Aspiration Pneumonia; CHF; Atrial Arrhythmia; ASCVD; Decubiti; Senile Dementia.</b>   |  |   |   |   |                           |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                           |  |
| 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |   |                           |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                           |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                           |  |
| 22a I certify that I (this hospital) attended the deceased from <b>10/27</b> , 19 <b>86</b> , to <b>11/11</b> , 19 <b>86</b> , that I (we) last saw the deceased alive on <b>11/11/86</b> , 19 <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.  |  |   |   |   |                           |  |
| 22b SIGNATURE<br><b>Andrew Gordon MD</b>   |  | DEGREE<br><b>MD</b>   |   | 22c DATE SIGNED<br><b>11/11/86</b>  |                           |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ANDREW GORDON MD</b>  |  | 22e ADDRESS<br><b>1657 Crofton Blvd Crofton MD 21114</b>  |   |   |                           |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b DATE<br><b>14 Nov 1986</b>  |   | 23c NAME OF CEMETERY OR CREMATORY<br><b>Washington National</b>   |                           |  |
| 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland PG Md</b>   |  |   |   |   |                           |  |
| 24 FUNERAL DIRECTOR'S NAME<br><b>Robert E Wilhelm</b>  |  | 24b ADDRESS<br><b>Suitland Md</b>   |   | 25a DATE REC'D. BY REGISTRAR<br><b>NOV 18 1986</b>  |                           |  |
| 25b REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |   |   |                           |  |

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

— 130 —

2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director for 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

023876 NOV 14 86

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 30384  
REG. NO. EST

|  |  |   |  |   |  |  |  |   |  |   |  |
|--|--|---|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JOSEPH RICHARD KOLODZIESKI SR   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 10, 1986  |  |  |  | 2b. HOUR<br>1250 AM   |  |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 3 22   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS.                                       |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | IF UNDER 24 HRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ANNE ARUNDEL COUNTY MD.                  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>GLEN BURNIE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NORTH ARUNDEL HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Truck Driver |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Dignan Transfer  |  |   |  |
| 13a. STATE<br>Maryland   |  |   |  | 13b. COUNTY<br>Anne Arundel   |  | 13c. CITY OR TOWN<br>Glen Burnie   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>116 Rosovelt Avenue, 21061  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Steven Kolodzieski   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Mierkiewicz   |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes WW II  |  |   |  | 16b. SOCIAL SECURITY NO.<br>215-12-7157   |  | 17. INFORMANT ADDRESS<br>Audrey Kolodzieski, 116 Rosovelt Avenue                 |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute pulmonary Edema</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Acute myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>2 days</u><br><u>2 days</u>   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-8</u> , 19 <u>86</u> , to <u>11-10</u> , 19 <u>86</u> , that (I) (we) lost<br>saw the deceased alive on <u>11-10</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><u>SANG C. DOI, M.D.</u>   |  |   |  | 22c. DATE SIGNED<br>11-15-86  |  |  |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SANG C. DOI, M.D.   |  |   |  | 22e. ADDRESS<br>95 AQUAHART ROAD<br>GLEN BURNIE MD 21051  |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   |  | 23b. DATE<br>11/13/86   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Park                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Elkridge Howard Maryland                          |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc., 4107 Wilkens Ave.  |  |   |  | 24b. ADDRESS<br>21229   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 12 1986                                     |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |   |  |

BP \_\_\_\_\_

SECRET

Handwritten notes and diagrams on lined paper, including a large 'X' and various illegible markings.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers (pages 1 and 2) and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body. The medical examiner must be notified at once. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause of death, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |   |   |  | REG. NO.  |  |
|---|--|--|--|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BARRY BARRY</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-07-86</b>                 |   |  | 2b. HOUR<br><b>10:45<sup>AM</sup></b>   |   |   |  |   |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>white</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 07 86</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br><b>1 1 45</b>           |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>1 45</b>                                 |  | IF UNDER 24 HRS<br>HOURS MIN.<br><b>1 45</b>    |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel County MD.</b>        |   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Anne Arundel General</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NA</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>NA</b>                                |  |   |  |
| 13a. USUAL RESIDENCE<br>(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>NA</b>  |  | 13b. CITY OR TOWN<br><b>NA</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13d. STREET ADDRESS / ZIP CODE<br><b>46 Sheridan Rd 21012</b>                 |   |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>DAVID F KOPACK</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELIZABETH C. UNKNOWN</b>  |  |   |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NA</b> |  |   |  |
| 16a. SOCIAL SECURITY NO.<br><b>NA</b>   |  |  |  | 17. INFORMANT<br><b>DAVID F Kopack</b>  |  |   |   | 17b. ADDRESS<br><b>46 Sheridan Rd MD 21012</b>                                |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>EXTREME PREMATURE</b>   |  |  |  |   |  |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____   |  |  |  |   |  |   |   |   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |  |  |   |  |   |   |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |   |  |   |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |  |   |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) |   |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>November 7, 1986</b> , to <b>Nov 7, 1986</b> , that (I) (we) last saw the deceased alive on <b>Nov 7, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>James H. Hoffman</b>   |  |  |  | DEGREE  |  |   |   | 22c. DATE SIGNED<br><b>11-8-86</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KEWETH Hoffman</b>  |  |  |  | 22e. ADDRESS  |  |   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  |  | 23b. DATE<br><b>11-12-86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview PK.</b>                      |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD.</b>        |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>T. A. Hagedorn</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 12 1986</b>   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John L. ...</b>                              |  |   |  |

BP

050055

1

2/2 1/2

11.2.25

Handwritten signature and text at the bottom right.



026281 DEC

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 3 0 3 8 0

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|  |  |  |  |   |   |  |  |   |  |  |
|--|--|--|--|---|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Frank N. Kopitsch</b>   |  |  | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>26</b> YEAR <b>86</b>                              |   |   | 2b. HOUR<br><b>5:50 A.M.</b>   |  |   |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>9</b> DAY <b>27</b> YEAR <b>1896</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b>   |  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>A.A. Co</b>   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Severna Park</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Meridian Convul. Ct.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>precision instrument maker</b>                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>private</b>   |  |  |
| 13a. STATE<br><b>md.</b>   |  | 13b. COUNTY<br><b>A.A. Co.</b>   |  | 13c. CITY OR TOWN<br><b>Millersville</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   | 13e. STREET ADDRESS / ZIP CODE<br><b>8358 Elm Rd. Millersville, Md. 2108</b> |  |
| 14. FATHER'S NAME<br>FIRST <b>Peter</b> MIDDLE <b>Kopitsch</b> LAST <b>LAST</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Margaret</b> MIDDLE <b>Mergand</b> LAST <b>LAST</b>  |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  |  |  | 16b. SOCIAL SECURITY NO<br><b>051-09-9731A</b>  |   | 17. INFORMANT<br>ADDRESS <b>Brian Whaite - sameas above</b>  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>b) <b>ASCVD CHF AF</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>c) <b>CVA rt hemiplegia</b>   |  |  |  |   |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>Ca of the prostate &amp; metastasis</b>   |  |  |  |   |   |  |  |   |  |  |
| 19a. DATE OF OPERATION<br><b>11 25 19 86</b>   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Ca of the prostate &amp; metastasis</b> |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                              |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                         |   |   | 21f. LOCATION<br>STREET  |  | CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11 25 19 86</b> to <b>11 26 19 86</b> , that (I) (we) last<br>saw the deceased alive on <b>11 25 19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Mustafa C. Oz MD</b>  |  |  | DEGREE   |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>11 26 86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mustafa C. Oz MD</b>   |  |  | 22e. ADDRESS<br><b>605 3rd Blvd SP MD 21186</b>  |   |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(IF)  |  |  | 23b. DATE<br><b>Nov 29, 1986</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven</b> |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Silver Spring Md</b>   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Donaldson Funeral Home Laurel</b>  |  |  | ADDRESS  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 03 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Tindon-Rodgers</b>   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon copies of Pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

02521 1-13

11-10-1934

U. S. District

U. S. District Court

U. S. District Court

U. S. District Court

U. S. District Court

U. S. District Court

U. S. District Court

U. S. District Court

U. S. District Court

U. S. District Court

U. S. District Court

U. S. District Court

U. S. District Court

U. S. District Court

U. S. District Court

U. S. District Court

U. S. District Court

U. S. District Court



025543 DEC

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

EST

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 20. DATE OF DEATH  |   | 26. HOUR   |  |
| ANNA THERESA KOSMICKI   |  | NOVEMBER 28, 1986  |   | 2.50 PM  |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                               | 7. IF UNDER 1 YEAR   |  |
| Female  | White  | NOV. 2, 1910   | 76  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |  |
| Baltimore, Md.  | U. S. A.   |  | ANNE ARUNDEL COUNTY MD.                                       |  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |
| GLEN BURNIE   | NORTH ARUNDEL HOSPITAL   |  | Housewife & Meat Packer                                       |  | Esskay Co.   |
| 13a. STATE  |  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS / ZIP CODE                                 |
| Md.   |  | AnneArundel  | Pasadena  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 7792 Fox Court- 21122.   |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |   |  |  |
| John --- Ramult   |  | Josephine --- Zwinska  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |  |
| No  |  | 213-03-9371  |   | Daughter; Mrs. Joseph Hutson-7792 Fox Court                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| PART 1. DEATH WAS CAUSED BY:  |  |  |   |  |  |
| IMMEDIATE CAUSE (a) Cardiorespiratory arrest  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |  |
| (b) Severe congestive heart failure   |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |  |
| (c)   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |
| Renal failure Diabetes  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|   |  |  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                       | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
|   |  | P.M. 19  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |
|   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19_____, to 19_____, that (I) (we) lost  |  |  |   |  |  |
| saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |
| 22b. SIGNATURE  |  | DEGREE   |   | 22c. DATE SIGNED   |  |
| [Signature]   |  | M.D.   |   | 11/28/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |   |  |  |
| BASANT K KHANDELWAL, M.D.   |  | 7422 BALTIMORE-ANNAPOLIS BLVD<br>GLEN BURNIE, MARYLAND 21061   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial  |  | Dec. 2, 1986   |   | Gardens of Faith   |  |
| 24. FUNERAL DIRECTOR NAME   |  | 24b. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |  |
| John A. Moran, Inc. Funeral Home  |  | DEC 01 1986  |   | Julia Davidson-Randall   |  |
| 3000 E. Baltimore St.; Balto., Md. 21224  |  |  |   |  |  |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove certificate 1 and 2 and forward to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

3. This certificate should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate 1 and 2 and forward to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

EST

05228 10-2500

MEMBER IN 1982 3.31

OSCAR

THREE

1971

White 1967 2, 1910 78

AGE KNOWN ONLY

W. S. A. x

H. S. A. 1967 2, 1910 78

NORTH AVENUE HOSPITAL

GEN BOWEN

1967 2, 1910 78

1967 2, 1910 78

Business

Locomotive

1967 2, 1910 78

1967 2, 1910 78

1967 2, 1910 78



1967 2, 1910 78

1967 2, 1910 78

1967 2, 1910 78

1967 2, 1910 78

1967 2, 1910 78

1967 2, 1910 78

1967 2, 1910 78

1967 2, 1910 78

1967 2, 1910 78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 0 3 8 8

1- FOR  
STATE  
REGISTRAR **Walter C. Krause**

REG. NO.

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>WALTER C. KRAUSE</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 12 86</b>                                  |   | 2b. HOUR<br><b>12 P</b><br>M   |
| 1. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 17 10</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b><br>YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL</b><br>MD.                      |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(GIVE NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ARUNDEL GERIATRIC NURS CTR.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Tire Builder</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Tire Manufacturing</b>   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>   | 13b. COUNTY<br><b>A.A.</b>  | 13c. CITY OR TOWN<br><b>PASADENA</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>    | 13e. STREET ADDRESS, ZIP CODE<br><b>227 HARLEM RD 21122</b>                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John G. Krause</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Klotz</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>214 05 9641</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Riviera Beach Md. 21122</b><br><b>Jean Sass 227 Harlem Rd.</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                             |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____ (b) _____ (c) _____<br><b>① ASCVD ② COPD</b>   |   |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/5</b> 19 <b>86</b> to <b>11/12</b> 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>11/7</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |   |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |   | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>11/12/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |   | 22e. ADDRESS  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>11/15/86</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park</b>                              |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto Balto Co Md.</b>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>George J. Gonce</b>  |   | BALTO. MD. ADDRESS<br><b>4001 Ritchie Hwy</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1986</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please take the certificate, pages 1 and 2, and have them filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "Not at Work", the medical examiner must be notified at once.

NOV 12 1955

RECEIVED

NOV 12 1955

NOV 12 1955

NOV 12 1955

NOV 12 1955

NOV 12 1955

NOV 12 1955

NOV 12 1955

NOV 12 1955

NOV 12 1955

NOV 12 1955

NOV 12 1955

NOV 12 1955

NOV 12 1955

NOV 12 1955

NOV 12 1955

NOV 12 1955

NOV 12 1955





24540 NOV 20 86

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Julius Kruesi</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 17 86</b>                 |   |  | 2b. HOUR<br><b>3:28</b> M  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8-28-1899</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Switzerland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel</b> MD   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Meridian Nursing Home</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Manager</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Trading Inter, Continent</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>3a. STATE<br><b>New York</b>   |  | 13b. COUNTY<br><b>Richmond</b>  |  | 13c. CITY OR TOWN<br><b>Staten Island</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>291 Boundary Avenue 10306</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ferdinand Kruesi</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Von Rotz</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>111-03-6212</b>  |  | 17. INFORMANT<br><b>Geraldine Kruesi</b>  |  | ADDRESS<br><b>Same as 13e</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Probable myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>atherosclerotic coronary vascular disease</b> |  |   |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>January 17, 1986</b> to <b>November 17, 1986</b> , that (I) (we) last saw the deceased alive on <b>November 17, 1986</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Jerry D. Skarbek</b>  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11-17-86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jerry D. SKARBK</b>  |  |   |  |   |  | 22e. ADDRESS<br><b>3908 Mountain Rd Pasadena And 11/2/86</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>11/20/86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Resurrection Cem.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Staten Island Richmond N.Y.</b> |  |  |
| 24. FUNERAL DIRECTOR<br><b>George J. Gonce</b>   |  |   |  |   |  | 4001 Ritchie Hwy Balto Md  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1986</b>  |  |
|  |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Tison-Randall</b>   |  |  |  |



25-51 11

of the

=====

0

SFS-FO-111

CONFIDENTIAL

*Journal of Management Education*

400

025780 DEC 3 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

30390

EST

REG. NO.

|  |  |   |   |   |                                   |
|--|--|---|---|---|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARGARET ELLEN KUNKEL</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 29, 1986</b>                                       |   | 2b. HOUR<br><b>1030 PM</b>        |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11-22-1900</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.   |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>                          |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Seamstress &amp; Homemaker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Anne Arundel</b>  | 13c. CITY OR TOWN<br><b>Pasadena</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George W. Hubbard, Sr.</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Florence E. Burns</b>   |   |   |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-09-3439 D</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>James J. Kunkel, Same as 13c</b>                                 |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Pulmonary Edema</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <b>Choke</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Choke</b> |  |   |   |   |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Alcoholism for Cardiovascular Disease</b>   |  |   |   |   |                                   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |   |   |                                   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |                                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                   |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>11 16</b> , 19 <b>86</b> , to <b>11 29</b> , 19 <b>86</b> , that (1) (we) lost saw the deceased alive on <b>11 29</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.                      |  |   |   |   |                                   |
| 22b. SIGNATURE<br><b>Ira H. Copeland</b>   |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>11/30/86</b>   |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>IRA H. COPELAND, M.D.</b>  |  | 22e. ADDRESS<br><b>95 AQUAHART ROAD, SUITE 203<br/>GLEN BURNIE, MARYLAND 21061</b>  |   |   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>12-3-86</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>                                |                                   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 1 1986</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Sanders-Randall</b>                                      |                                   |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



024648 NOV 20 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

30391

REG. NO.

|  |  |   |   |   |   |
|--|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Jeanne R. Lawrence                  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 13 86                               |   | 2b. HOUR<br>10:40 AM  |
| 3. SEX<br>Female   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 25, 1910   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.                            | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                 |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Alabama                        | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>A.A.Co. MD.                           |   |   |
| 10. CITY OR TOWN OF DEATH<br>Severna Park                                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Meridian Nurs. Ho. Severna Md. Park |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY                                     |   |
| 13a. STATE<br>Maryland   |  |   | 13b. COUNTY<br>A.A.Co.  | 13c. CITY OR TOWN<br>Pasadena   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>Orley C. Rush   |  |   | 15. MOTHER'S MAIDEN NAME<br>Winifred ----- Osborne                            |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO |  | 16b. SOCIAL SECURITY NO.<br>420-34-1694   |   | 17. INFORMANT<br>ADDRESS<br>Mr. George B. Lawrence, Jr. Same as above |   |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Chronic Lung disease |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |

|   |  |  |   |
|---|--|--|---|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |   |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (1) this hospital attended the deceased from 6-26 19 85, to 11-13 19 86, that (1) we lost<br>saw the deceased alive on 11-11 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) did (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br>Thomas Walsh  | DEGREE<br>MD   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br>11-13-86  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>THOMAS WALSH MD  |  | 22e. ADDRESS<br>780 Ritchie Hwy Severna Park Md 21146  |   |

|  |           |   |  |
|--|-----------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                   | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY<br>Bayview Mem. Park | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Pensacola, Escambia Co. Fla. |
| 24. FUNERAL DIRECTOR<br>NAME<br>McCully Funeral Home, Mt. & Tickneck Rds |           | 25a. DATE REC'D. BY REGISTRAR<br>NOV 18 1986            | 25b. REGISTRAR'S SIGNATURE   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



024203 NOV 18 86

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 30392  
REG. NO.

EST

|   |  |  |   |   |                             |   |  |  |  |
|---|--|--|---|---|-----------------------------|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>NEA S LECOMTE</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 16, 1986</b> |   | 2b. HOUR<br><b>655 M PM</b> |   |  |  |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>W</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JULY 10 1905</b>   |                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>U.S.A. MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b>                       |   |   |                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TEACHER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BALTO CITY SCHOOLS</b>   |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>  |   | 13c. CITY OR TOWN<br><b>CATONSVILLE</b>   |                             | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  | 13e. STREET ADDRESS / ZIP CODE<br><b>112 PARK AVE 21228</b>      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>FRANK SCHLEGEL</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>  |   |   |                             | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>212-26-4639</b>  |  | 17. INFORMANT<br><b>SEPA</b>   |   |   |                             | ADDRESS<br><b>112 PARK AVE CATONSVILLE MD 21228</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for each part)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>OSCAR</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>OSCAR</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I<br><b>1. OVA 2. dehydration 3. g-I retention</b> |  |  |   |   |                             |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                             | 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21; PART I OR PART 2)  |                             |   |  |  |  |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                             |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/31</b> , 19 <b>86</b> , to <b>11/16</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>11/16</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |   |   |                             |   |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  | DEGREE<br><b>MD</b> - ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   |                             | 22c. DATE SIGNED<br><b>11/17/86</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>EDWARD J. JONES, M.D.</b>   |  | 22e. ADDRESS<br><b>BROADNECK MEDICAL CENTER 273 E PENNSYLVANIA FARM ROAD, ARNOLD MD 21012</b>  |   |   |                             |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>   |  | 23b. DATE<br><b>11/17/86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WESTVIEW MEM. PARK</b>   |                             | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE COUNTY MD.</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>JOSEPH L. CANBY</b>  |  | ADDRESS<br><b>12590 INDIAN HILL DRIVE WEST FRIENDSHIP MD 21144</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 17 1986</b>   |                             | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

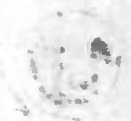
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15, 4)

2001 10 10 10 10 10 10



100% COTTON FIBERS

100% COTTON FIBERS

*[Faint, mostly illegible text and markings on the left side of the page, possibly bleed-through from the reverse side.]*



025170 NOV 25-85

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 0 3 9 3

REG. NO.

|  |  |  |   |  |  |   |  |   |  |
|--|--|--|---|--|--|---|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Bertie M. Lee  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 24, 1986  |  |  | 2b. HOUR<br>M   |  |   |  |
| 3. SEX<br>Female   |  | 4 RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 1, 1929  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>57 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Wisconsin   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel County MD.                                  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Annapolis   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Anne Arundel General Hospital |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Med. Secretary   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |   |  |  |   |  |   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>AA  |   | 13c. CITY OR TOWN<br>Glen Burnie   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>401 W. Furnace Branch Rd. 21061   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William A. Purkins   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Vesta E. Gohl   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-26-9135   |   | 17. INFORMANT<br>ADDRESS<br>Glen Burnie, MD<br>Mrs. Jane Purkins, 401 W. Furnace Branch Rd.  |  |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Colonic carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 years</u>  |  |
| MEDICAL CERTIFICATION  |  |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><u>11/24/84</u>           |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/14/84</u> , 19____, to <u>11/23/86</u> , 19____, that (I) (we) lost saw the deceased alive on <u>11/23/86</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Stuart E. Selouick</u>  |  |  | DEGREE  |  |  | 22c. DATE SIGNED<br><u>11/24/86</u>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Stuart E. Selouick, M.D.   |  |
| 22e. ADDRESS<br>51 Franklin St Annapolis, 21401  |  |  | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  |  | 23b. DATE<br>Nov. 24, 86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Security Process Inc.                    |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville Baltimore MD |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>James S. Kirkley, Glen Burnie, MD  |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 25 1986  |  | 25b. REGISTRAR<br><u>Julia Denson</u>   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 as any injury, or other traumatic event, the medical examiner must be notified at once.

05212

QVAD

MINIATURE

NOT FOR REPRODUCTION



MOA SE 1956  
The American Museum of Natural History

025907 DEC 13

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

3 0 3 9 4

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>RITA M. LEE  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 26 86   |  | 2b. HOUR<br>3:04 P.M.  |
| 3. SEX<br>FEMALE   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 10 27  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore Md.   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel MD.                       |  |
| 10. CITY OR TOWN OF DEATH<br>Edgewater   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4147 Shoreham Beach Rd |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Morse Associate             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Retail Sales  |
| 13a. STATE<br>Md.  | 13b. COUNTY<br>A.A.   | 13c. CITY OR TOWN<br>Edgewater  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>4147 Shoreham Beach Rd. 21037                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles S. TRABING   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Weidner   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>NA 217-24-6560   | 17. INFORMANT<br>ADDRESS<br>LAWRENCE Lee #13C   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metastatic Breast Cancer<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 1/2 years |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/27, 1984, to 11/26, 1986, that (I) (we) lost<br>saw the deceased <u>on</u> 11/20, 1986, and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated<br>(above) (I) (we) (did) (did not) view the body after death.  |   |   |   |  |  |
| 22b. SIGNATURE<br>E. W. Cole III   |   | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>11/26/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>E. W. COLE III  |   | 22e. ADDRESS<br>51 FRANKLIN ST ANNAP. Md.   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(BY)<br>Burial  | 23b. DATE<br>12-1-86  | 23c. NAME OF CEMETERY OR CREMATORY<br>Hillcrest Cem.  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Annapolis A.A. Md.               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>T. A. Hardesty   |   | ADDRESS<br>Annapolis Md. 2101   |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 2 1986                                    | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward this certificate, Pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

022001 EC-012

20% COTTON 100% BEE

Okie

023334 NOV - 7 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

EST

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SOON R LEE</b>   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 3, 1986</b>                                       |   | 2b. HOUR AM PM<br><b>130 AM</b>  |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>ORIENTAL</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 16 12</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>South Korea</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>South Korea</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>                            |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF IN BALTIMORE CITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Homemaker</b>                     |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |   |   | 13b. COUNTY<br><b>A.A.</b>  | 13c. CITY OR TOWN<br><b>Severn</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>215 96 7252</b>  | 17. INFORMANT ADDRESS<br><b>Severn, Maryland 21144</b><br><b>Gi Dong Rhee 8312 Deer Run Court</b> |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Ascaris</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c)<br><b>Ascaris</b> |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>9/08 1986</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                    |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/08</b> 19 <b>86</b> , to <b>11/3</b> 19 <b>86</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/3</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Elmo M. Gayoso</b>   |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>11/3/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ELMO M. GAYOSO, M.D.</b>  |   | 22e. ADDRESS<br><b>5411 OLD FREDERICK ROAD<br/>BALTIMORE, MARYLAND 21229</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   | 23b. DATE<br><b>11/5/86</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Park</b>   | 23d. LOCATION<br>(CITY OR TOWN) COUNTY STATE<br><b>Elkridge Howard Md</b>                         |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Raymond C. Fink</b>  |   | ADDRESS<br><b>Glen Burnie, Md 21061</b>   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 6 1986</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |

MEDICAL CERTIFICATION

9/9

1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

GEORGETOWN NEWS  
PUBLISHED WEEKLY  
BY THE GEORGETOWN NEWS COMPANY

| DATE |  | PAGE |  | PRICE    |  |
|------|--|------|--|----------|--|
| 1911 |  | 1    |  | 10 CENTS |  |
| 1912 |  | 2    |  | 10 CENTS |  |
| 1913 |  | 3    |  | 10 CENTS |  |
| 1914 |  | 4    |  | 10 CENTS |  |
| 1915 |  | 5    |  | 10 CENTS |  |
| 1916 |  | 6    |  | 10 CENTS |  |
| 1917 |  | 7    |  | 10 CENTS |  |
| 1918 |  | 8    |  | 10 CENTS |  |
| 1919 |  | 9    |  | 10 CENTS |  |
| 1920 |  | 10   |  | 10 CENTS |  |
| 1921 |  | 11   |  | 10 CENTS |  |
| 1922 |  | 12   |  | 10 CENTS |  |
| 1923 |  | 13   |  | 10 CENTS |  |
| 1924 |  | 14   |  | 10 CENTS |  |
| 1925 |  | 15   |  | 10 CENTS |  |
| 1926 |  | 16   |  | 10 CENTS |  |
| 1927 |  | 17   |  | 10 CENTS |  |
| 1928 |  | 18   |  | 10 CENTS |  |
| 1929 |  | 19   |  | 10 CENTS |  |
| 1930 |  | 20   |  | 10 CENTS |  |
| 1931 |  | 21   |  | 10 CENTS |  |
| 1932 |  | 22   |  | 10 CENTS |  |
| 1933 |  | 23   |  | 10 CENTS |  |
| 1934 |  | 24   |  | 10 CENTS |  |
| 1935 |  | 25   |  | 10 CENTS |  |
| 1936 |  | 26   |  | 10 CENTS |  |
| 1937 |  | 27   |  | 10 CENTS |  |
| 1938 |  | 28   |  | 10 CENTS |  |
| 1939 |  | 29   |  | 10 CENTS |  |
| 1940 |  | 30   |  | 10 CENTS |  |
| 1941 |  | 31   |  | 10 CENTS |  |
| 1942 |  | 32   |  | 10 CENTS |  |
| 1943 |  | 33   |  | 10 CENTS |  |
| 1944 |  | 34   |  | 10 CENTS |  |
| 1945 |  | 35   |  | 10 CENTS |  |
| 1946 |  | 36   |  | 10 CENTS |  |
| 1947 |  | 37   |  | 10 CENTS |  |
| 1948 |  | 38   |  | 10 CENTS |  |
| 1949 |  | 39   |  | 10 CENTS |  |
| 1950 |  | 40   |  | 10 CENTS |  |
| 1951 |  | 41   |  | 10 CENTS |  |
| 1952 |  | 42   |  | 10 CENTS |  |
| 1953 |  | 43   |  | 10 CENTS |  |
| 1954 |  | 44   |  | 10 CENTS |  |
| 1955 |  | 45   |  | 10 CENTS |  |
| 1956 |  | 46   |  | 10 CENTS |  |
| 1957 |  | 47   |  | 10 CENTS |  |
| 1958 |  | 48   |  | 10 CENTS |  |
| 1959 |  | 49   |  | 10 CENTS |  |
| 1960 |  | 50   |  | 10 CENTS |  |
| 1961 |  | 51   |  | 10 CENTS |  |
| 1962 |  | 52   |  | 10 CENTS |  |
| 1963 |  | 53   |  | 10 CENTS |  |
| 1964 |  | 54   |  | 10 CENTS |  |
| 1965 |  | 55   |  | 10 CENTS |  |
| 1966 |  | 56   |  | 10 CENTS |  |
| 1967 |  | 57   |  | 10 CENTS |  |
| 1968 |  | 58   |  | 10 CENTS |  |
| 1969 |  | 59   |  | 10 CENTS |  |
| 1970 |  | 60   |  | 10 CENTS |  |
| 1971 |  | 61   |  | 10 CENTS |  |
| 1972 |  | 62   |  | 10 CENTS |  |
| 1973 |  | 63   |  | 10 CENTS |  |
| 1974 |  | 64   |  | 10 CENTS |  |
| 1975 |  | 65   |  | 10 CENTS |  |
| 1976 |  | 66   |  | 10 CENTS |  |
| 1977 |  | 67   |  | 10 CENTS |  |
| 1978 |  | 68   |  | 10 CENTS |  |
| 1979 |  | 69   |  | 10 CENTS |  |
| 1980 |  | 70   |  | 10 CENTS |  |
| 1981 |  | 71   |  | 10 CENTS |  |
| 1982 |  | 72   |  | 10 CENTS |  |
| 1983 |  | 73   |  | 10 CENTS |  |
| 1984 |  | 74   |  | 10 CENTS |  |
| 1985 |  | 75   |  | 10 CENTS |  |
| 1986 |  | 76   |  | 10 CENTS |  |
| 1987 |  | 77   |  | 10 CENTS |  |
| 1988 |  | 78   |  | 10 CENTS |  |
| 1989 |  | 79   |  | 10 CENTS |  |
| 1990 |  | 80   |  | 10 CENTS |  |
| 1991 |  | 81   |  | 10 CENTS |  |
| 1992 |  | 82   |  | 10 CENTS |  |
| 1993 |  | 83   |  | 10 CENTS |  |
| 1994 |  | 84   |  | 10 CENTS |  |
| 1995 |  | 85   |  | 10 CENTS |  |
| 1996 |  | 86   |  | 10 CENTS |  |
| 1997 |  | 87   |  | 10 CENTS |  |
| 1998 |  | 88   |  | 10 CENTS |  |
| 1999 |  | 89   |  | 10 CENTS |  |
| 2000 |  | 90   |  | 10 CENTS |  |
| 2001 |  | 91   |  | 10 CENTS |  |
| 2002 |  | 92   |  | 10 CENTS |  |
| 2003 |  | 93   |  | 10 CENTS |  |
| 2004 |  | 94   |  | 10 CENTS |  |
| 2005 |  | 95   |  | 10 CENTS |  |
| 2006 |  | 96   |  | 10 CENTS |  |
| 2007 |  | 97   |  | 10 CENTS |  |
| 2008 |  | 98   |  | 10 CENTS |  |
| 2009 |  | 99   |  | 10 CENTS |  |
| 2010 |  | 100  |  | 10 CENTS |  |



24219 NOV 18 1986

FOR  
STATE  
REGISTRAR

# DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30390  
REG. NO.

|  |                    |   |   |  |
|--|--------------------|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>AKA: ROSIE VICTORIA LEWIS</b><br><i>Rose Victoria Lewis</i>   |                    | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 19 <b>12 19 86</b>                                     |   | 2b. HOUR M 1337  |
| 3. SEX <b>F</b>  | 4. RACE <b>Can</b> | 5. DATE OF BIRTH MONTH DAY YEAR <b>8 25 16 70</b> YRS.  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.                        | 7c. DATE PRONOUNCED DEAD <b>12 19 86</b>   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>   |                    | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>   |                    | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Arundel Hosp</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>   |
| 13a. STATE <b>MD</b>   |                    | 13b. COUNTY <b>AA</b>   |   | 13c. CITY OR TOWN <b>Millersville</b>  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Nicholas Giardina</b>   |                    | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth (Unknown)</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>   |                    | 16b. SOCIAL SECURITY NO. <b>214-18-5360</b>   |   | 17. INFORMANT ADDRESS <b>Elizabeth R. Dove, 7900 Aiken Ave.</b>  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <b>A.S.C.V.D.</b><br>(b) <b>DUE TO, OR AS A CONSEQUENCE OF</b><br>(c)   |                    |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I   |                    |   |   |  |
| 19a. DATE OF OPERATION   |                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                    | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                    | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                    |   |   |  |
| ACTUAL SIGNATURE <i>William P. Jones</i>   |                    | TITLE (SPECIFY) <b>M.D. Deputy</b>  |   | DATE SIGNED <b>11/12/86</b>  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>William P. Jones, M. D.</b>   |                    | ADDRESS <b>695 America Crt. Davidsonville, Md. 21035</b>  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |                    | 23b. DATE <b>Nov. 15, 1986</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>                      |  |
| 23d. LOCATION CITY OR TOWN <b>Timonium</b>   |                    | COUNTY <b>Balto.</b> STATE <b>Md.</b>   |   |  |
| 24. FUNERAL DIRECTOR <b>ROBERT C. ALTENBURG FUNERAL HOME, INC.</b>   |                    | 25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1986</b>  |   | 25b. REGISTRAR'S SIGNATURE <i>Julia Anderson-Randall</i>   |
| 6009 Harford Rd., Balto., Md. 21214  |                    |   |   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE REASON FOR DELAY. 2. AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THIS PAGE. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M
 BP  
DHMH - 17  
(VR A15 ME (5))



1991

023525 NOV 12 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

EDT

|  |  |  |   |   |                                    |  |  |
|--|--|--|---|---|------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>RUSSELL W LINDSEY</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 05, 1986</b> |   | 2b. HOUR<br>AM PM<br><b>817 AM</b> |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 27, 1971</b>  |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br>MONTHS DAYS HOURS MIN.<br><b>15 YRS</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington, D.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                   |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY</b><br>MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT A HOSPITAL, NURSING HOME, ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>student</b>  |                                    | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>  |  |  |   | 13b. COUNTY<br><b>A.A.</b>  |                                    | 13c. CITY OR TOWN<br><b>Pasadena</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John W. Lindsey</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sharon R. Richardson</b>  |                                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-98-0663</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Sharon R. France, same as 13e</b>  |                                    |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>AORTIC ROOT RUPTURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>AORTIC DEGENERATION OF MARFAN'S SYNDROME</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |   |   |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.   |  |  |   |   |                                    |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                    | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                    |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                    |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |                                    |  |  |
| 22b. SIGNATURE<br><i>Martin Berger M.D.</i>  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |                                    | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARTIN BERGER, M.D.</b>  |  |  |   | 22e. ADDRESS<br><b>7424 BALTIMORE ANNAPOLIS BOULEVARD<br/>GLEN BURNIE, MARYLAND 21061</b>   |                                    |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/7/86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Mem. Park</b>  |                                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Howard Co., Maryland</b>                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>George J. Gonce, 4001 Ritchie Hwy., Baltimore, MD</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV - 6 1986</b>  |                                    | 25b. REGISTRAR'S SIGNATURE<br><i>Via [Signature]</i>   |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Their plates relative to the permit. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as either shows any injury, or significant injury, or significant injury, the medical examiner must be notified at once.

BP \_\_\_\_\_  
DHMH - 16 50M 4/83  
(VRA 15, 4)

(21225)

053258 NOV 1946

NOVEMBER 20, 1946

LIBRARY

ASIAN - 4

NOV 22 1946

WASH. STATE LIBRARY

ASIAN - 4

3

WASH. STATE LIBRARY

NOV 22 1946

WASH. STATE LIBRARY

ASIAN - 4



025585 DEC - 2

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM WM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |           |   |        |  |                         |   |                   |   |                          |              |          |
|---|-----------|---|--------|--|-------------------------|---|-------------------|---|--------------------------|--------------|----------|
| DECEASED NAME<br>(TYPE OR PRINT)  |           | FIRST   | MIDDLE | LAST   | 7a. DATE KNOWN OF DEATH |   | 7b. DATE OF DEATH | MONTH   | DAY                      | YEAR         | 2b. HOUR |
| Michael   |           | V.  |        | Lockard  | 11                      |   | 11                | 24  | 19                       | 86           | M        |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  |        | 6. AGE (IN YEARS)  | IF UNDER 1 YR.          |   | IF UNDER 24 HRS.  |   | 7c. DATE PRONOUNCED DEAD |              | 2d. HOUR |
| Male  | Caucasian | SEPT 12, 1969   |        | 17   | YRS.                    |   | MONTHS            |   | 11                       |              | 2:50P    |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |           | 7b. CITIZEN OF WHAT COUNTRY?  |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                         | 9. BALTIMORE CITY OR COUNTY OF DEATH  |                   |   |                          |              |          |
| Maryland  |           | USA   |        |  |                         | Anne Arundel County, MD   |                   |   |                          |              |          |
| 10. CITY OR TOWN OF DEATH   |           | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        |  |                         | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |                   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                          |              |          |
| Crofton   |           | 1800 Seton Drive (parking lot)  |        |  |                         | Student   |                   | School  |                          |              |          |
| 13a. STATE  |           |   |        |  |                         |   |                   |   |                          |              |          |
| Maryland  |           |   |        |  |                         |   |                   |   |                          |              |          |
| 13b. COUNTY   |           | 13c. CITY OR TOWN   |        | 13d. INSIDE CITY LIMITS?   |                         | 13e. STREET ADDRESS   |                   |   |                          |              |          |
| Anne Arundel  |           | Crofton   |        | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                         | 1854 Neumann Way 21114  |                   |   |                          |              |          |
| 14. FATHER'S NAME   |           |   |        | 15. MOTHER'S MAIDEN NAME   |                         |   |                   | ADDRESS   |                          |              |          |
| Robert D. Lockard   |           |   |        | Ellen L. Franklin  |                         |   |                   | 1854 Neumann Way Crofton, MD 21114                                  |                          |              |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |           |   |        | 16b. SOCIAL SECURITY NO.   |                         | 17. INFORMANT   |                   |   |                          |              |          |
| NO  |           |   |        | 216-04-9857  |                         | Robert D. Lockard   |                   |   |                          |              |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gunshot wound of head</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |           |   |        |  |                         |   |                   |   |                          |              |          |
| 19a. DATE OF OPERATION  |           |   |        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                         |   |                   | 20. AUTOPSY?  |                          |              |          |
|   |           |   |        |  |                         |   |                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                          |              |          |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |           |   |        | 21b. TIME OF INJURY  |                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                   |   |                          |              |          |
|   |           |   |        | ? P.M. 11 24 1986  |                         | self inflicted  |                   |   |                          |              |          |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK   |           |   |        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |                         | 21f. LOCATION   |                   | CITY OR TOWN  |                          | COUNTY STATE |          |
|   |           |   |        | parking lot  |                         | 1800 Seton Drive, Crofton,  |                   | A.A. CO, MD.  |                          |              |          |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |           |   |        |  |                         |   |                   |   |                          |              |          |
| ACTUAL SIGNATURE  |           |   |        | TITLE (SPECIFY)  |                         |   |                   | DATE SIGNED   |                          |              |          |
| <i>William M. Zane</i>  |           |   |        | Assistant  |                         |   |                   | 11/25/86  |                          |              |          |
| EXAMINER'S NAME (TYPE OR PRINT)   |           |   |        | ADDRESS  |                         |   |                   |   |                          |              |          |
| William M. Zane, M.D.   |           |   |        | 111 Penn St. Balto. MD.  |                         |   |                   |   |                          |              |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |           | 23b. DATE   |        | 23c. NAME OF CEMETERY OR CREMATORY   |                         | 23d. LOCATION   |                   |   |                          |              |          |
| Burial  |           | NOV 28, 1986  |        | Maryland Veterans Cem.   |                         | Crownsville, Anne Arundel, MD   |                   |   |                          |              |          |
| 24. FUNERAL DIRECTOR NAME   |           |   |        | 25a. DATE REC'D. BY REGISTRAR  |                         |   |                   | 25b. REGISTRAR'S SIGNATURE  |                          |              |          |
| Beall Funeral Home  |           |   |        | DEC 1 1986   |                         |   |                   | <i>Julia T. ...</i>   |                          |              |          |

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

Walt Cannonball 12, 1950

Maryland

School Student

1024 Newman Way, 2114

Trotton

Anne Trumbull

Yonkers

L.

Ellis

Lockard

E.

Robert

1024 Newman Way  
Trotton, MD 2114

Robert D. Lockard

210-04-9851

NO

NOTED 8:00 AM

025810 DEC 30

Item # 5,6,13e,17, Film G 622, 12/18/86 ra  
 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |                           |  |  |
|---|--|--|--|---|---------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HARRY RAE LOHMAN</b> |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 25 86</b> |   | 2b. HOUR<br><b>2100</b> M |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>CAUC.</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 25 1920</b>  |                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> 66 YRS<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PA.</b>                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL CO.</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>ANNAPOLIS</b>                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ARUNDEL GEN. HOSP.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>BUILDER &amp; DEVELOPER</b>  |                           | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>Q.A.</b>   |  | 13c. CITY OR TOWN<br><b>STEVENSVILLE</b>  |                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      |  |
| 13e. STREET ADDRESS / ZIP CODE<br><b>909 Monroe Manor Road 21666</b>                |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HARRY RAE LOHMAN</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELIZABETH GOOD</b>  |                           | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES W. WII</b> |  |
| 16b. SOCIAL SECURITY NO.<br><b>169-14-8486</b>                                      |  | 17. INFORMANT<br><b>Katherine M. LOHMAN</b>  |  | 17. ADDRESS<br><b>909 Monroe Manor Road</b>   |                           |  |  |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Peritonitis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Ischemic necrosis of colon</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Rupture Abdominal Aortic Aneurysm</b>  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>48 hrs</b><br><b>48 hrs</b><br><b>2 wks</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><b>Diabetes mellitus; Renal Failure due to acute tubular necrosis</b>  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>11/10/86</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Ruptured Aneurysm</b> |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11/25/86</b>           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)       |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) <b>did</b> <del>was</del> hospital attended the deceased from <b>11/10/86</b> , 19 <b>86</b> , to <b>11/25</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>11/25/86</b> , 19 <b>86</b> , and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) <b>did</b> <del>did not</del> view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br><b>David C Green MD</b>  |  |  |  | 22c. DATE SIGNED<br><b>11/24/86</b>  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>David C Green MD</b>   |  |  |  | 22f. ADDRESS<br><b>706 Biddings Ave Annapolis MD 21401</b>                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>  |  | 23b. DATE<br><b>11-26-86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SECURITY PROCESSING BALTO. BALTO. CO. MD.</b>         |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>TOM HELFENBEIN FUNERAL HOME</b>   |  | 24b. ADDRESS<br><b>RT#1 Box 66-B CHESTER MD 21619</b>                        |  | 25a. DATE REC'D BY REGISTRAR<br><b>DEC 1 1986</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Julia Dendron-Randall</b>   |  |  |  |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked either (a) or (b), the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |  |  |   |  |   |   |  |  |  |
|--|--|--|--|--|---|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HELEN GERTRUDE LOKER</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Nov. 2, 1986</b>  |  |   | 2b. HOUR <b>10</b> MIN. <b>30</b> AM   |   |   |  |  |  |
| 3 SEX<br><b>female</b>   |  | 4 RACE<br><b>white</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>10-09-1905</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.                                     |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wash. D.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel Co. MD.</b>                  |   |   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Edgewater</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Pleasant Living Nursing Center</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>housewife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>household</b>   |  |  |  |
| 13a. STATE<br><b>Md.</b>   |  |  | 13b. COUNTY<br><b>A.A. Co.</b>   |  | 13c. CITY OR TOWN<br><b>Shady Side</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John J. Hughes</b>   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Bridget Boucher</b>   |  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>       |   |   | 16b. SOCIAL SECURITY NO.<br><b>577-28-2305</b> |  |  |
| 17 INFORMANT ADDRESS<br><b>Anne Oelkrug 4967 Lerch Dr. Sahdy Side Md.</b>  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>chronic obstructive Pul Dis</b><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause lost. |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 MIN</b><br><b>4 Hrs</b>         |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>   |  |  |  |  |   |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)        |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |   | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE   |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 1975</b> to <b>Nov 86</b> that (I) (we) lost the deceased alive on <b>10/11</b> 19 <b>86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |   |   |  |  |  |
| 22b. SIGNATURE OF PHYSICIAN<br><b>Dr. Weintraub</b>  |  |  |  |  |   | 22c. DATE SIGNED<br><b>11/3/86</b>   |   | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>11/5/86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OUR LADY OF SORROWS WEST RIVER, A.A. MD.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>HARDESTY FUNERAL HOME 12 RIDGELY AVE. ANN. MD.</b>   |  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 5 1986</b>                                   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Tindon-Randall</b>   |  |  |  |

BP

023282 200-208

200% CATION FIBER



WAVE

024366 NOV 9 1986

ON ST., BALTIMORE, MARYLAND 21201

DIVISION OF VITAL RECORDS, 20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send the permit to the funeral home. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. (Permit to be removed.)

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |   |   |  | REG. NO. 86 30401                            |  |
|---|--|--|--|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>William Arthur LOWMAN  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>November 15, 1986  |   |   | 2b. HOUR<br>1:30 P.M.   |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Aug. 7, 1918   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                               |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel MD   |   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Glen Burnie  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>North Arundel Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Insurance Sales                |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Metropolitan               |  |  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Anne Arundel  |  | 13c. CITY OR TOWN<br>Linthicum  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br>7 Mansion Road 21090          |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Arthur Lowman  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Laura Acree   |  |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>1935/1937  |  | 17. INFORMANT<br>Ruth Lowman (Wife)   |  | ADDRESS<br>Same as 13   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARCINOMA OF LUNGS, RIGHT LUNG</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>LOBE WITH METASTASES</u><br>(b) <u>TO THE RIPS AND SKULL</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____  |  |  |  |   |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                     |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                           |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)               |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |   |  |  |  |
| 22a. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>7/1/86</u> to <u>10/13</u> 19 <u>86</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>10/3</u> 19 <u>86</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did)</u> not view the body after death.  |  |  |  |   |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><u>E. Kasitis</u>   |  |  | DEGREE   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED<br><u>11/17/86</u>                             |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Edmund Kasitis MD  |  |  | 22e. ADDRESS<br>1801 Frederick Road, Catonsville, Md.                                |   |  |   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  | 23b. DATE<br>Nov. 19, 1986   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery  |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brooklyn A.A. Md. |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <u>A.B. Wilson</u> ADDRESS _____   |  |  | 25a. DATE REC'D. BY REGISTRAR 11/18/86 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> |   |  |   |   |   |  |  |  |
| Singleton Funeral Home, Glen Burnie, Md.  |  |  |  |   |  |   |   |   |  |  |  |

001-206450

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **30402**

FOR  
1- STATE  
REGISTRAR

|  |                         |   |  |   |  |  |  |   |  |   |   |
|--|-------------------------|---|--|---|--|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Timothy</b>  |                         | FIRST   |  | MIDDLE  |  | LAST<br><b>Lugenbeel</b>   |  | 2a. DATE OF DEATH<br>KNOWN <input checked="" type="checkbox"/> ESTI-<br>MATED <input type="checkbox"/> MONTH DAY YEAR<br><b>11 25, 86</b> |  | 2b. HOUR<br><b>3:30A</b>  |   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec 31 1963</b>  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br><b>22</b> YRS.  |  | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>22</b>                             |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>22</b>   |  | 2c. DATE<br>PRONOUNCED<br>DEAD<br><b>11 25, 86</b>                                  |   |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br><b>Maryland</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> *EVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel County, MD</b> |  |   |  |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore-Washington Parkway</b> |  |   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br><b>Laborer</b>  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |   |
| 13a. STATE<br><b>Ind.</b>  |                         |   |  | 13b. COUNTY<br><b>INDIANAPOLIS</b>  |  | 13c. CITY OR TOWN<br><b>Indianapolis</b>                               |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>10929 W. Rockville Rd. 46234</b>                          |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Leonard Carl Lugenbeel Sr.</b>  |                         |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Killmayer</b>  |  |  |  |   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>no</b>   |                         |   |  | 16b. SOCIAL SECURITY NO.<br><b>214-72-5343</b>  |  |  |  | 17. INFORMANT<br><b>Nancy Lugenbeel</b> ADDRESS<br><b>10929 W. Rockville Rd.</b>  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple injuries</b><br><b>8147</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |                         |   |  |   |  |  |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                         |   |  |   |  |  |  |   |  |   |   |
| 19a. DATE OF OPERATION   |                         |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>1:35 11 25, 86</b>  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Pedestrian struck by auto</b>                         |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK   |                         |   |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br><b>road</b>   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Baltimore-Washington Pkwy, A.A. CO, MD.</b>                                       |  |   |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |  |   |  |  |  |   |  |   |   |
| ACTUAL SIGNATURE<br><i>[Signature]</i>   |                         |   |  | TITLE (SPECIFY)<br>M.D. <b>Assistant</b>  |  |  |  | DATE<br>SIGNED <b>11/25/86</b>  |  |   |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>William M. Zane, M.D.</b>  |                         |   |  | ADDRESS <b>111 Penn St. Balto. MD.</b>  |  |  |  |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |                         |   |  | 23b. DATE<br><b>11/29/86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OakLawnCemetery</b>           |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>             |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>ConnellyFuneralHome 300MaceAve. 21221</b>   |                         |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 01 1986</b>                    |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |   |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER WITH FORM-PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

052053 10-503

RECEIVED 11 FEB 1964

ALBANY, NEW YORK



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

024335 NOV 18 1986

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |                           |  |
|---|--|--|--|--|---------------------------|--|
| 1. DECEASED NAME<br>FIRST MIDDLE LAST<br><b>DONALD E. MACKIN</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>November 7 1986</b>         |  | 2b. HOUR<br><b>2025 M</b> |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>1 22 27</b>                                    |                           |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS<br><b>0 0</b>  |  | IF UNDER 24 HRS. HOURS MIN.<br><b>0 0</b>  |                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ohio</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel Co. MD.</b>                  |                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Anne Arundel General Home</b>         |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Engineer</b>     |                           |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  | 13a. STREET ADDRESS / ZIP CODE<br><b>6 Tydings Rd. 21146</b>   |  | 13b. STREET ADDRESS / ZIP CODE   |                           |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>William Mackin</b>  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Jennie Mackin</b> |  |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>WW 11 284-22-4393</b>   |  | 17. INFORMANT ADDRESS<br><b>Deruthea Mackin Same as Above # 13</b>                   |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of Pn Esophagus</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>30 min</b><br><b>1 month</b> |  |  |  |  |                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |  |                           |  |
| 19a. DATE OF OPERATION<br><b>10/16/86</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Carcinoma of Esophagus</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                           |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                       |                           |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B: PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                  |                           |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  | 21g. LOCATION STREET CITY OR TOWN COUNTY STATE   |  | 21h. LOCATION STREET CITY OR TOWN COUNTY STATE                                       |                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/16/86</b> 19____ to <b>11/7/86</b> 19____, that (I) (we) last saw the deceased alive on <b>11/7/86</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |                           |  |
| 22b. SIGNATURE DEGREE<br><b>David C Green MD</b>  |  |  |  | 22c. DATE SIGNED   |                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>David C Green MD</b>  |  |  |  | 22e. ADDRESS<br><b>706 Giddings Ave, Annapolis MD</b>                                |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11-10-86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MD Veterans Cem.</b>                        |                           |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Crownsville, AA MD</b>  |  | 23e. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1986</b>  |  | 23f. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                          |                           |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Barranco F.H.</b>   |  | 24b. ADDRESS<br><b>501 Ritchie Hwy Severna Park MD</b>   |  | 24c. ADDRESS<br><b>21146</b>   |                           |  |

MEDICAL CERTIFICATION





5  
024796 NOV 2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30404  
REG. NO.

|  |  |                     |  |   |  |   |  |   |  |   |  |   |  |  |  |  |  |  |  |
|--|--|---------------------|--|---|--|---|--|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HAROLD EGBERT Mac KNIGHT</b>  |  |                     |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11 13 86</b> |  |   |  | 2b. HOUR OF DEATH<br><b>1248 P M</b>         |  |  |  |  |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>W</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>DEC 25 1907 78 YRS.</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>78 YRS.</b>       |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   |  | IF UNDER 24 HRS.<br>HOURS MIN   |  | 2c. DATE PRONOUNCED DEAD<br><b>11 13 86</b>   |  |  |  | 2d. HOUR<br><b>M</b>                                       |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW YORK</b>   |  |                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL MD.</b>                                 |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>ANNAPOLIS</b>  |  |                     |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ANNE ARUNDEL</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ATTORNEY</b>  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |  |  |
| 13a. STATE<br><b>MD</b>  |  |                     |  | 13b. COUNTY<br><b>ANNE ARUNDEL</b>  |  |   |  | 13c. CITY OR TOWN<br><b>Fairhaven</b>   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  | 13e. STREET ADDRESS<br><b>6454 Weems Ave DUNKIRK 20754</b> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>BERT Mac Knight</b>   |  |                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MAY Nichols</b>   |  |   |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>YES</b>  |  |                     |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>UNKNOWN</b>   |  |   |  | 17. INFORMANT<br><b>Richard MacKnight</b>   |  |   |  | ADDRESS<br><b>SAME AS #13</b>   |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE CORONARY INSUFFICIENCY</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <b>CARDIO VASCULAR ATHEROSCLEROSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>TUBERCOLE</b>                         |  |                     |  |   |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>TUBERCO ABUSE</b>  |  |                     |  |   |  |   |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                     |  |   |  |   |  |   |  |   |  |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Charles A. Seager</b>  |  |                     |  |   |  | TITLE (SPECIFY)<br>M.D. <b>DEPUTY</b> MEDICAL EXAMINER  |  |   |  |   |  | DATE SIGNED <b>11/14/86</b>   |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>CHARLES A. SEAGER</b>   |  |                     |  |   |  | ADDRESS <b>780 RITCHIE HWY SV. PK, MD.</b>              |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>  |  |                     |  | 23b. DATE<br><b>NOV 14 1986</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill</b> |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>SWITLAND P.G. MD</b>                                   |  |   |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>BAUSCH Funeral Home OWINGS MD</b>   |  |                     |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1986</b>     |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Swenson-Rodman</b>   |  |   |  |  |  |  |  |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

051300 NOV 51

051300 NOV 51



0800 1 NOV

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

EST

FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>GENEVIEVE VERONICA MATHEWS  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 12, 1986               |   |  | 2b. HOUR<br>1:40 PM   |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 31 1928   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 74 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Rhode Island  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ANNE ARUNDEL COUNTY MD.               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>GLEN BURNIE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NORTH ARUNDEL HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Domestic  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>Rhode Island Providence  |  |   |  | 13b. COUNTY<br>Cranston   |  | 13c. CITY OR TOWN<br>Cranston   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edward J. Mockler, Sr.   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Genevieve V. Gleason   |  | 13e. STREET ADDRESS / ZIP CODE<br>20 Harmony Ave.                             |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>039-16-2481   |  | 17. INFORMANT<br>Edward Mathews 20 Harmony Ave. Cranston, R.I.  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CLINICAL BRAIN DEATH<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CEREBRAL INFARCTION<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) MASSIVE INTRAVENTRICULAR HEMORRHAGE<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/11/86 to 11/12/86, that (I) (we) last saw the deceased alive on 11/12/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                       |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>David Tolner M.D.  |  |   |  |   | DEGREE   |   | 22c. DATE SIGNED<br>11/12/86   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DAVID TOLNER, M.D.  |  |   |  |   | 22e. ADDRESS<br>7310 RITCHIE HIGHWAY<br>GLEN BURNIE, MARYLAND 21061            |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   | 23b. DATE<br>11-15-86  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Ann's Cemetery                       |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cranston Providence R.I. |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>MARZULLO FUNERAL SERVICE   |  |   |  |   | ADDRESS<br>UPPERCO, MD   |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 13 1986                           |  |  |
|  |  |   |  |   | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall                           |   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as either (b) shows any injury, or other traumatic event, the medical examiner must be notified at once.

021011 110150

NOV 11 1950

RECEIVED

11/11/50

RECEIVED



NOV 11 1950

NOV 11 1950

024247 NOV 18 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

86 30400

|   |   |   |  |  |   |
|---|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LOUISE E. MATTHEWS</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/12/86</b>                               |  | 2b. HOUR<br><b>5:15 PM</b>  |
| 3. SEX<br><b>F</b>  | 4. RACE<br><b>Negro</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 24 93</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>93</b>   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>YES - USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>A.A.</b>                                      |   |
| 10. CITY OR TOWN OF DEATH<br><b>Millersville, Md</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Krollwood Manor</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>housewife</b> | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. STATE<br><b>MARYLAND</b>   |   |   | 13b. COUNTY<br><b>A.A.</b>   | 13c. CITY OR TOWN<br><b>ANNAPOLIS</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN H. JOHNSON</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SARAH SNOWDEN</b>                |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br><b>NO</b> (NO OR UNKNOWN)   |   | 16b. SOCIAL SECURITY NO.<br><b>217-14-0297</b>  |  | 17. INFORMANT<br><b>Annapolis, Md 21401</b><br><b>GLORIA P. HALL 680 Greenbrier Lane</b> |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio Resp Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Uremia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Chronic</b><br><b>Chronic</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Chronic</b><br><b>Congestive Heart Failure</b> |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>Chronic</b>   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |
| 22a. I certify that (1) this hospital attended the deceased from <b>Aug</b> 19 <b>81</b> , to <b>Nov 12</b> 19 <b>86</b> , that (2) (we) last saw the deceased alive on <b>Nov 11</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.  |   |   |  |  |   |
| 22b. SIGNATURE<br><b>Barry P. Nathanson</b>   |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>11/13/86</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BARRY P. NATHANSON</b>  |   | 22e. ADDRESS<br><b>51 FRANKLIN ST. ANNAP.</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |   | 23b. DATE<br><b>11-18-1986</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PINELAWN MEM PARK</b>                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Annapolis A.A. Maryland</b>  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1986</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Robinson</b>   |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

2

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913

1913



024047 NOV 14 1986

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 30407

REG. NO.

|   |  |  |   |  |   |  |   |   |  |
|---|--|--|---|--|---|--|---|---|--|
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Naomi (NMN) McCauley  |  |  |   | 2a DATE OF DEATH MONTH DAY YEAR<br>November 8, 1986  |   |  |   | 2b HOUR<br>10 PM  |  |
| 3 SEX<br>Female   |  | 4 RACE<br>White  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>November 11, 1901   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS   |   | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>A A Co. MD.   |   |   |  |
| 10 CITY OR TOWN OF DEATH<br>Glen Burnie   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>North Arundel Conv. Center |   |  |   | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |   | 12b KIND OF BUSINESS OR INDUSTRY<br>Own Home  |  |
| 13a STATE<br>Maryland   |  | 13b COUNTY<br>A A Co.  |   | 13c CITY OR TOWN<br>Severn   |   | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 13e STREET ADDRESS / ZIP CODE<br>1426 Washington Ave. 21144   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Frank Keffer  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mollie Zeller   |   | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)<br>No  |   |  |   |   |  |
| 16b SOCIAL SECURITY NO.<br>214.12.8665  |  | 17 INFORMANT (Cousin)<br>Mr. James T. Care   |   |  |   | ADDRESS 8260 Quarterfield Road<br>Severn, Md. 21144  |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio Vascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u> |  |  |   |  |   |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |   |  |   |   |  |
| 19a DATE OF OPERATION   |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                   |  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19            |  |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f LOCATION STREET CITY OR TOWN COUNTY STATE  |   |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>5-1</u> , 19 <u>86</u> to <u>11-8</u> , 19 <u>86</u> that (I) (we) lost<br>saw the deceased alive on <u>11-8</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |   |  |   |   |  |
| 22b SIGNATURE<br><u>SANF C. DOTT</u> M.D.   |  |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c DATE SIGNED<br>11-10-86   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>SANG C. DOTT M.D.   |  |  |   |  |   | 22e ADDRESS<br>Suite 131, 95 Aquahart Road, Glen Burnie, Md.   |   |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  | 23b DATE<br>Nov 12, 1986  |  | 23c NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem. Park |  | 23d LOCATION CITY OR TOWN COUNTY STATE<br>Glen Burnie A A Co. Md. |   |  |
| 24 FUNERAL DIRECTOR NAME<br>Singleton Funeral Home  |  |  |   |  |   | 25a DATE REC'D BY REGISTRAR<br>NOV 13  |   | 25b REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return pages 1 and 2 to the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other condition present, a medical examiner must be notified at once.

051011 1001 14 02

93H11 101103 2003

WILKINSON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send your completed pages 1 and 2 to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

6638

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |  |  |
|--|--|--|--|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James Daniel McGuire, Sr.   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11/17/86                        |   |  | 2b. HOUR<br>9:18PM  |   |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>W   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 22 08   |  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>WASH. DC  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel MD   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Edgewater   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Pleasant Living Convalescent Center |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CONTRACTOR |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Construction  |  |
| 13a. STATE<br>MD   |  |  | 13b. COUNTY<br>A.A.  |   | 13c. CITY OR TOWN<br>DAVIDSONVILLE   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Colin C. McGuire   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Alice - Curnyn        |   |  | 13e. STREET ADDRESS / ZIP CODE<br>P.O. Box 69, 21035  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-01792-A |   | 17. INFORMANT<br>Terence McGuire   |   |   | ADDRESS<br>P.O. Box 69<br>DAVIDSONVILLE MD   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Parkinson Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a<br><u>Renal Disease</u>   |  |  |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>11/16</u> 19 <u>86</u> , to <u>11/17</u> 19 <u>86</u> , that (1) (we) last saw the deceased alive on <u>11/16</u> 19 <u>86</u> , and that in (2) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.                 |  |  |  |   |  |   |   |  |  |
| 22b. SIGNATURE<br>Terence A. McGuire   |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>11/18/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Terence A. McGuire  |  |  |  |   |  | 22e. ADDRESS<br>311 Addison Road Seat Pleasant, Md.   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23b. DATE<br>11/21/86  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Resurrection Cemetery                    |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Clinton, Prince George's Md.                      |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Lee Funeral Home, Inc.   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 24 1986  |   |  |  |
| 25b. REGISTRAR'S SIGNATURE<br>John J. Anderson   |  |  |  |   |  |   |   |  |  |

152521 100230

37

V

A 2U

34 42 V



12/8/59

12/8/59

A A

B 11

21/1

21/1

21/1

21/1



12/8/59

x

12/8/59

12/8/59

+

12/8/59

023511 NOV 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

86

30409

|  |  |   |   |  |  |   |  |
|--|--|---|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Esther Mabel Michalsen</b>  |  |   | 2a. DATE OF DEATH MONTH <b>11</b> DAY <b>4</b> YEAR <b>86</b> |  |  | 2b. HOUR <b>A</b> - <b>M</b>  |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>White</b>  |   | 5. DATE OF BIRTH MONTH <b>Sept</b> DAY <b>16</b> YEAR <b>1910</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>Annapolis</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hospital</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>   |  |
| 13a. STATE <b>MD</b>   |  | 13b. COUNTY <b>A.A.</b>   |   | 13c. CITY OR TOWN <b>Annapolis</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS / ZIP CODE <b>195 Americana Drive Apt A-21403</b>  |  | 14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>Henrihan</b> LAST <b>Almyra</b>   |   | 15. MOTHER'S MAIDEN NAME FIRST <b>Almyra</b> MIDDLE <b>Hitchcock</b> LAST <b>Hitchcock</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO. <b>338-34-0550</b>   |   | 17. INFORMANT <b>Stanley G. Michalsen</b>  |  | ADDRESS <b>same as #13</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Breast Cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b> |  |   |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____   |  |   |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>7/3/85</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>7/3/85</b>   |   | 21f. LOCATION STREET <b>11/4/86</b>  |  | CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/3/85</b> , 19____, to <b>11/4/86</b> , 19____, that (I) (we) last saw the deceased alive on <b>11/3/86</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |  |   |  |
| 22b. SIGNATURE <b>Stuart E. Selouch, M.D.</b>  |  |   |   | DEGREE <b>M.D.</b>   |  | 22c. DATE SIGNED <b>11/4/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stuart E. Selouch, M.D.</b>   |  |   |   | 22e. ADDRESS <b>51 Franklin St. Annapolis, Md 21014</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>   |  | 23b. DATE <b>Nov. 5, 1986</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>   |  | 23d. LOCATION CITY OR TOWN <b>Suitland</b> COUNTY <b>PG</b> STATE <b>MD</b>   |  |
| 24. FUNERAL DIRECTOR NAME <b>Taylor Funeral Chapel - Annapolis, MD</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR <b>NOV - 6 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Asia Denson-Rodgers</b>   |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked "X", item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove appropriate Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

BP



025653 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

30410

REG. NO.

|  |  |   |  |   |                                 |  |  |  |
|--|--|---|--|---|---------------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>LEO G. MICKAIL Sr.  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 28, 1986   |   | 2b. HOUR EST<br>10:15 AM        |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 12 16  |                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS.<br>IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.              |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ANNE ARUNDEL COUNTY MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br>GLEN BURNIE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NORTH ARUNDEL HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Remodler  |                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>Self Emp.   |  |  |
| 13a. STATE<br>Pa.  |  |   | 13b. COUNTY<br>Alleghany   |   | 13c. CITY OR TOWN<br>Pittsburgh |  | 13d. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Maranio  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Theresa Mazza   |   |                                 | 16. SOCIAL SECURITY NO.<br>206 01 2684   |  |  |
| 17. INFORMANT<br>21108<br>Leo G. Mickail Jr 955 Oakdale Circle   |  |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Ruptured abdominal aortic aneurysm<br>DUE TO, OR AS A CONSEQUENCE OF (b) Left Cerebro Vascular accident<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c) |   |                                 |  |  |  |
| 19a. DATE OF OPERATION<br>11/28  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Critical  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                                 |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                 |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/28, 1986, to 11/28, 1986, that (I) (we) last saw the deceased alive on 11/28, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |                                 |  |  |  |
| 22b. SIGNATURE<br>SANG K. HAN, M.D.  |  | 22c. ADDRESS<br>21061 7845 Oakwood Road #204 Glen Burnie, Md.   |  | 22d. DATE SIGNED<br>NOV 28 1986   |                                 | 22e. REGISTERAR'S SIGNATURE<br>Julie Anderson-Randall  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Entombment  |  | 23b. DATE<br>12/3/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Alleghany Memorial  |                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>McCandless Alleghany Pa  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Raymond C. Fink Glen Burnie, Md 21061  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 28 1986  |  | 25b. REGISTRAR'S SIGNATURE  |                                 |  |  |  |

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)







SECRET 11/7/58

SEPTEMBER 11, 1958

MEMORANDUM

TO: THE DIRECTOR

FROM: [illegible]

SUBJECT: [illegible]

1. [illegible]  
2. [illegible]  
3. [illegible]  
4. [illegible]  
5. [illegible]  
6. [illegible]  
7. [illegible]  
8. [illegible]  
9. [illegible]  
10. [illegible]  
11. [illegible]  
12. [illegible]  
13. [illegible]  
14. [illegible]  
15. [illegible]  
16. [illegible]  
17. [illegible]  
18. [illegible]  
19. [illegible]  
20. [illegible]  
21. [illegible]  
22. [illegible]  
23. [illegible]  
24. [illegible]  
25. [illegible]  
26. [illegible]  
27. [illegible]  
28. [illegible]  
29. [illegible]  
30. [illegible]  
31. [illegible]  
32. [illegible]  
33. [illegible]  
34. [illegible]  
35. [illegible]  
36. [illegible]  
37. [illegible]  
38. [illegible]  
39. [illegible]  
40. [illegible]  
41. [illegible]  
42. [illegible]  
43. [illegible]  
44. [illegible]  
45. [illegible]  
46. [illegible]  
47. [illegible]  
48. [illegible]  
49. [illegible]  
50. [illegible]  
51. [illegible]  
52. [illegible]  
53. [illegible]  
54. [illegible]  
55. [illegible]  
56. [illegible]  
57. [illegible]  
58. [illegible]  
59. [illegible]  
60. [illegible]  
61. [illegible]  
62. [illegible]  
63. [illegible]  
64. [illegible]  
65. [illegible]  
66. [illegible]  
67. [illegible]  
68. [illegible]  
69. [illegible]  
70. [illegible]  
71. [illegible]  
72. [illegible]  
73. [illegible]  
74. [illegible]  
75. [illegible]  
76. [illegible]  
77. [illegible]  
78. [illegible]  
79. [illegible]  
80. [illegible]  
81. [illegible]  
82. [illegible]  
83. [illegible]  
84. [illegible]  
85. [illegible]  
86. [illegible]  
87. [illegible]  
88. [illegible]  
89. [illegible]  
90. [illegible]  
91. [illegible]  
92. [illegible]  
93. [illegible]  
94. [illegible]  
95. [illegible]  
96. [illegible]  
97. [illegible]  
98. [illegible]  
99. [illegible]  
100. [illegible]



FOR: [illegible]

DATE: [illegible]

RECEIVED [illegible] NOV 3 1958

025067 NOV 25 1986  
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.  
IMPORTANT: If item 21 is marked as item 4E, then any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 6 3 0 4 1 2<br>REG. NO. EST  |  |
|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |
| DECEASED NAME (NAME OR PRINT) FIRST MIDDLE LAST<br>SOPHIE ANNA MONESKI   |  |   |  | NOVEMBER 22, 1986  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>12 15 16  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ANNE ARUNDEL COUNTY MD.                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |  |
| 10. CITY OR TOWN OF DEATH<br>GLEN BURNIE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NORTH ARUNDEL HOSPITAL                            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home Maker  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>A.A.   |  | 13c. CITY OR TOWN<br>Pasadena  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary Anne Wolak   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>217-03-8775   |  | 17. INFORMANT ADDRESS<br>Pasadena, Md 21122<br>Paul A. Moneski 271 Hickory Point Road        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiogenic shock</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>massive myocardial infarction</u><br><u>acute ventricular failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>acute MI</u><br><u>acute renal failure</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>COPD</u>   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><u>N/A</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>N/A</u>  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)<br><u>N/A</u>  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 19, 1986</u> to <u>Nov 22, 1986</u> , that (I) (we) lost <u>Nov 22, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Benjamin A. de Guzman, M.D.</u>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><u>Nov. 23, 1986</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BENJAMIN A. DE GUZMAN   |  | 22e. ADDRESS<br>325 HOSPITAL DRIVE SUITE 108<br>GLEN BURNIE, MD 21061   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>11/25/86   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Cross Cemetery                                    |  |
| 23d. LOCATION<br>Baltimore   |  | COUNTY<br>A.A.  |  | STATE<br>Md  |  |
| 24. FUNERAL DIRECTOR<br>George J. Gonce 4001 Ritchie Hwy Balto Md  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 24 1986   |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>                                  |  |



025378

NOV 28 1986  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10.1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

|  |                    |   |   |   |  |  |  |  |  |
|--|--------------------|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Elmer Eugene Morris, Jr.</b>  |                    |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED <input type="checkbox"/> 11-22-86 |   |  | 2b. HOUR <b>M</b>  |  |  |  |
| 3. SEX <b>M</b>  | 4. RACE <b>CAU</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>8-11-58</b>   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>28 YRS.</b>  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   | 7c. DATE PRONOUNCED DEAD <b>11-22-86</b> | 2d. HOUR <b>0335</b>   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |                    | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>AA Co.</b>   |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Annapolis</b>   |                    | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel Gen</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mason</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Bricklayer</b>  |  |  |  |
| 13a. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Md.</b>   |                    | 13b. COUNTY <b>AA</b>   |   | 13c. CITY OR TOWN <b>Shady Side</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS <b>1221 Pine Ave</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Elmer Eugene Morris</b>  |                    | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Eleanor Rose Graham</b>  |   | 16. SOCIAL SECURITY NO. <b>214-72-3784</b>  |  | 17. INFORMANT ADDRESS <b>Jacqueline S. Morris Same as #13</b>                                |  |  |  |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>   |                    | 18b. SOCIAL SECURITY NO. <b>214-72-3784</b>   |   | 18c. INFORMANT ADDRESS <b>Jacqueline S. Morris Same as #13</b>  |  | 18d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: <b>Chest Head Trauma</b><br>IMMEDIATE CAUSE (a) <b>8129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Motor Vehicle Accident.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |                    |   |   |   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a   |                    |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR <b>0230 22 Nov 86</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Head on collision</b>  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                    | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Street</b>   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE <b>Muddy Crk Rd AA Md.</b>  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                    |   |   |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>William P. Jones</b>   |                    | TITLE (SPECIFY) <b>M.D. Deputy</b>  |   | MEDICAL EXAMINER  |  |  |  | DATE SIGNED <b>11-22-86</b>              |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |                    | ADDRESS   |   |   |  |  |  |  |  |
| 23a. BURIAL CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |                    | 23b. DATE <b>11-25-86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Brentwood PG Md.</b>                           |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Hardesty F.H.</b>  |                    | ADDRESS <b>Annapolis, Md.</b>   |   | 25a. DATE REC'D. BY REGISTRAR <b>NOV 26 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Julia Benson-Randall</b>                                       |  |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

052114-14512

22



NOV 28 1950



Void Certificate

#86-30414



026340 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RE-RAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRARDECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

ESBER

MOUBAYED

2a. DATE KNOWN  
OF ESTI-  
DEATH MATED

MONTH DAY YEAR

2b. HOUR

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

Mar. 13 1906

6. AGE (IN YEARS)

80

IF UNDER 1 YR.

MONTHS DAYS HOURS MIN.

IF UNDER 24 HRS.

7c. DATE

PRONOUNCED  
DEAD

MONTH DAY YEAR

2d. HOUR

7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)

Lebanon

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Anne Arundel County

MD.

10. CITY OR TOWN OF DEATH

Annapolis

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
Anne Arundel General Hosp.12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE)

Sales

12b. KIND OF BUSINESS  
OR INDUSTRY

Self Employed

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Anne Arundel

13c. CITY OR TOWN

Annapolis

13d. INSIDE CITY LIMITS?

YES ☐ NO ☐

13e. STREET ADDRESS

130 Hearne Road

21401

14. FATHER'S NAME

FIRST  
Nicholas

MIDDLE

E.

LAST  
Moubayed

15. MOTHER'S MAIDEN NAME

FIRST  
Asma

MIDDLE

LAST  
Nader

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO, OR UNKNOWN)  
N/A(IF YES, GIVE WAR OR DATES)  
N/A

16b. SOCIAL SECURITY NO.

578-30-4626

17. INFORMANT

(nephew) ADDRESS

Nicholas Hamaty-1007 Loxford Terr. S.S. Md. 20901

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Multiple injuries

DUE TO, OR AS A CONSEQUENCE OF

8150  
Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause last.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR  
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR MIN. MONTH DAY YEAR  
2:30 M. 11-29-19 86

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)

Driver of auto/fixed object impact.

21d. INJURY OCCURRED

WHILE  
AT WORK ☐ NOT WHILE  
AT WORK ☒21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)

road

21f. LOCATION

STREET  
5800 blk. Grenger Rd.

CITY OR TOWN

COUNTY

Anne Arundel

STATE

MD

22. I certify that I have charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opiniondeath resulted from: Natural causes ☐ Accidental ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

Charles P. Kokes

TITLE (SPECIFY)

M.D. Assistant MEDICAL EXAMINER

DATE SIGNED 11-30-86

EXAMINER'S NAME  
(TYPE OR PRINT)

Charles P. Kokes, M.D.

ADDRESS 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

Dec. 4, 1986

23c. NAME OF CEMETERY OR CREMATORY

Gate of Heaven Cemetery

23d. LOCATION  
CITY OR TOWN

Silver Spring Montgomery Md.

COUNTY

STATE

24. FUNERAL DIRECTOR

Hines/Rinaldi Funeral Home

ADDRESS 11800 N.H. Ave.,

Silver Spring, Md.

25a. DATE REC'D. BY REGISTRAR

DEC 5 1986

25b. REGISTRAR'S SIGNATURE

Asia Gordon-Rodriguez



024368

NOV 19 05

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

30410

REG. NO.

EST

|   |  |   |  |   |  |   |   |  |   |  |
|---|--|---|--|---|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>HELEN (NMI) MYTYCH   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 16, 1986                     |   |  | 2b. HOUR<br>2.15 AM   |   |  |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 25, 1912  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.                                    |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Poland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ANNE ARUNDEL COUNTY MD.               |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>GLEN BURNIE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NORTH ARUNDEL HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |   |  |
| 13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>Anne Arundel  |   | 13c. CITY OR TOWN<br>Hanover   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>7433 Ridge Road 21076 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Francis Swietyniowski   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sophia Karp  |  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A               |   | 17. INFORMANT (Son)<br>Mr. Alex W. Mytych  |   | ADDRESS<br>143 Kilpatrick Rd.<br>Clewiston, Florida 33440                                       |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Cardio-pulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septic Shock - Acute Septicemia - Sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute Myocardial Infarction</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hr</u><br><u>36 hours</u><br><u>12 hrs</u> |  |   |  |   |  |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a  |  |   |  |   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)       |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |   |  |
| 22a. I certify that (I) <u>Elliot Corbaty</u> attended the deceased from <u>11/14/86</u> , 19 <u>86</u> , to <u>11/16</u> , 19 <u>86</u> , that (I) <u>we</u> last saw the deceased alive on <u>11/15</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death, so state.)  |  |   |  |   |  |   |   |  |   |  |
| 22b. SIGNATURE<br><u>Elliott Corbaty</u>  |  |   | DEGREE<br><u>MD</u>  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><u>11/19/86</u>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ELLIOTT CORBATY, M.D.  |  |   | 22e. ADDRESS<br>7845 OAKWOOD ROAD, SUITE 203<br>GLEN BURNIE, MARYLAND. 21061 |   |  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Entombment   |  |   | 23b. DATE<br>Nov. 19, 1986   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem. Park   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie, A.A. Maryland                        |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Singleton Funeral Home  |  |   |  |   | ADDRESS<br>Glen Burnie, Maryland   |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 18 1986  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>        |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

02A 622 11102

RECEIVED 10 1 1964

100%

100% COTTON

100% COTTON

100% COTTON



100% COTTON

100% COTTON

024309 NOV 8 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

EST

|   |  |   |   |   |   |  |   |  |  |  |
|---|--|---|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>GEORGE THOMAS NIZER  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 13, 1986                          |   |   | 2b. HOUR<br>217 AM   |   |  |  |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>CAUCASIAN  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 15 09   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U S A   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ANNE ARUNDEL COUNTY MD.                      |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>GLEN BURNIE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NORTH ARUNDEL HOSPITAL |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>WELDER           |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Shipbuilding  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br>Maryland   |  |   | 13b. COUNTY<br>A.A.   |   | 13c. CITY OR TOWN<br>Glen Burnie  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>327 Thelma Avenue 21061  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>GEORGE K. NIZER   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ANNA NORTON                      |   |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213 07 7145            |   | 17. INFORMANT<br>Glen Burnie, Maryland 21061<br>Richard D Nizer 327 Thelma Avenue |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Hypertension</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Minutes</u><br><u>Years</u><br><u>Years</u>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b)<br><u>Organic Brain Syndrome</u>   |  |   |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><u>Nov 13</u>   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Organic Brain Syndrome</u> |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 1 19                      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)     |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)            |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |  |  |
| 22a. I certify that (b) (this hospital) attended the deceased from <u>Nov 13</u> , 19 <u>86</u> , to <u>Nov 13</u> , 19 <u>86</u> , that (we) lost saw the deceased alive on <u>Nov 13</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did not) view the body after death.  |  |   |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Peter H. Rheinstein, MD</u>  |  |   | DEGREE<br>M.D.  |   |   | 22c. DATE SIGNED<br>Nov 13, 1986   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PETER H. RHEINSTEIN, M. D.   |  |   | 22e. ADDRESS<br>621 HOLLY RIDGE ROAD<br>SEVERNA PARK, MARYLAND 21146              |   |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |   | 23b. DATE<br>11/14/86   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Oaklawn Cemetery                            |  |   | 23d. LOCATION<br>Baltimore City Md.  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Raymond C. Fink Glen Burnie, Md 21061   |  |   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 4 1986  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Ann... Radack</u>   |  |  |

MEDICAL CERTIFICATION

729

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be filed in the funeral director's office. It should be detached for use as the burial-transit permit. Then please remove carbon papers. Registration should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



024000 101000



024161 NOV 13 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |   |  |   |  |  |  |
|---|--|---|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>TEDD Y WALTER NOWAK</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 16, 1986</b>            |   | 2b. HOUR<br><b>1:30a.m.</b>   |  |   |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 25, 1924</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel County</b> MD.               |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Odenton</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>618 Chapel Gate Dr. (21113)</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Military</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Marine Corp.</b>  |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>A.A.</b>   |   | 13c. CITY OR TOWN<br><b>Odenton</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>618 Chapel Gate Dr. (21113)</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Walter Nowak</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Eva Wojciechowska</b>  |   |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>'43- '71</b> |   | 17. INFORMANT<br>ADDRESS<br><b>Sandra Nowak, (same as 13e)</b>                      |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Adeno Carcinoma.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic Lung disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Cancers</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |   |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>no</b>   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>none</b>            |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>          |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)      |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1982</b> , 19____, to <b>1986</b> , 19____, that (I) (we) last saw the deceased alive on <b>10/86</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>C. L. HAYE</b>   |  |   | DEGREE<br><b>Attending Physician</b>                                       |   |   | 22c. DATE SIGNED<br><b>17 Nov-86</b>   |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>O. L. HAYE</b>  |  |   | 22e. ADDRESS<br><b>Kembranch Army Hospital</b>                             |   |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>11/19/86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>                     |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arlington, Virginia</b>   |  |  |
| 24. FUNERAL DIRECTOR<br><b>George J. Gonce,</b><br><b>4001 Ritchie Hwy., Baltimore, MD. 21225</b>   |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 17 1986</b>                                  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician, it should be detached for use on the burial/transit permit. This permit should be filed with the funeral director. Pages 1 and 2 should be filed with the funeral director. Pages 3 and 4 should be filed with the funeral director. Pages 5 and 6 should be filed with the funeral director. Pages 7 and 8 should be filed with the funeral director. Pages 9 and 10 should be filed with the funeral director. Pages 11 and 12 should be filed with the funeral director. Pages 13 and 14 should be filed with the funeral director. Pages 15 and 16 should be filed with the funeral director. Pages 17 and 18 should be filed with the funeral director. Pages 19 and 20 should be filed with the funeral director. Pages 21 and 22 should be filed with the funeral director. Pages 23 and 24 should be filed with the funeral director. Pages 25 and 26 should be filed with the funeral director. Pages 27 and 28 should be filed with the funeral director. Pages 29 and 30 should be filed with the funeral director. Pages 31 and 32 should be filed with the funeral director. Pages 33 and 34 should be filed with the funeral director. Pages 35 and 36 should be filed with the funeral director. Pages 37 and 38 should be filed with the funeral director. Pages 39 and 40 should be filed with the funeral director. Pages 41 and 42 should be filed with the funeral director. Pages 43 and 44 should be filed with the funeral director. Pages 45 and 46 should be filed with the funeral director. Pages 47 and 48 should be filed with the funeral director. Pages 49 and 50 should be filed with the funeral director. Pages 51 and 52 should be filed with the funeral director. Pages 53 and 54 should be filed with the funeral director. Pages 55 and 56 should be filed with the funeral director. Pages 57 and 58 should be filed with the funeral director. Pages 59 and 60 should be filed with the funeral director. Pages 61 and 62 should be filed with the funeral director. Pages 63 and 64 should be filed with the funeral director. Pages 65 and 66 should be filed with the funeral director. Pages 67 and 68 should be filed with the funeral director. Pages 69 and 70 should be filed with the funeral director. Pages 71 and 72 should be filed with the funeral director. Pages 73 and 74 should be filed with the funeral director. Pages 75 and 76 should be filed with the funeral director. Pages 77 and 78 should be filed with the funeral director. Pages 79 and 80 should be filed with the funeral director. Pages 81 and 82 should be filed with the funeral director. Pages 83 and 84 should be filed with the funeral director. Pages 85 and 86 should be filed with the funeral director. Pages 87 and 88 should be filed with the funeral director. Pages 89 and 90 should be filed with the funeral director. Pages 91 and 92 should be filed with the funeral director. Pages 93 and 94 should be filed with the funeral director. Pages 95 and 96 should be filed with the funeral director. Pages 97 and 98 should be filed with the funeral director. Pages 99 and 100 should be filed with the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

051101 101100

THE HANNA BOND

20% GOLD FIBER



025960 DEC 3 1986

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  | EST  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EDWARD Albert OTT</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 30, 1986</b>  |  | 2b. HOUR<br><b>728 PM</b>  |  |
| 3 SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 17, 1898</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Machinist</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>B &amp; O R/R</b>  |  |
| 13a. STATE<br><b>Maryland</b>  |  |  |  | 13b. COUNTY<br><b>Anne Arunde</b>   |  | 13c. CITY OR TOWN<br><b>Pasadena</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Ott</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maggie Gleichman</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>705.05.3559</b>   |  | 17. INFORMANT <b>Step Son</b> ADDRESS<br><b>Donald E. Smith Same as 13</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Senile Urinary tract infection</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><u>Old stroke with dysphagia and gastrostomy</u> |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>Nov 17, 1986</u> to <u>Nov 30, 1986</u> , that (I) (we) last saw the deceased alive on <u>Nov 30, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>PO-HSLU HUNG, M.D.</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><u>Dec. 1, '86</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PO-HSLU HUNG, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>3450 FT. MEADE ROAD<br/>LAUREL, MARYLAND 20707</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Dec, 3, 1986</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem'l Park</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie A.A. Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Singleton Funeral Home, Glen Burnie, Md.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 2 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>  |  |

MEDICAL CERTIFICATION

9821

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DEC 8 1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |                                   |  |  |   |  |
|---|--|---|---|---|-----------------------------------|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MARIE OWENS</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11/03/86</b> |   | 2b. HOUR<br><b>7A<sup>M</sup></b> |  |  |   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>N</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>09 01 00</b>  |                                   | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br><b>86</b>                       |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL</b> MD.        |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>ANNAPOLIS</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ANNE ARUNDEL HOSPITAL</b> |   |   |                                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>ANNE ARUNDEL</b> 13c. CITY OR TOWN <b>ANNAPOLIS</b>   |  |   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                   | 13e. STREET ADDRESS / ZIP CODE<br><b>3 ROSECREST DR 21403</b>          |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>WILLIAM HALL</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME MIDDLE LAST<br><b>MATILDA ENNIS</b>  |                                   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217 30 3004</b>  |   | 17. INFORMANT ADDRESS<br><b>Annapolis, Md. 21401</b><br><b>GEORGIA EVANS 519 Royal Street</b>   |                                   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular occlusion</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |   |   |                                   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 wks.</b>   |  |
|   |  |   |   |   |                                   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>Hepatitis, probably non-A, non-B</b>   |  |   |   |   |                                   |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |                                   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                   |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>10176 4/3 1986</b>   |                                   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/3/86</b> to <b>11/3/86</b> , that (I) (we) lost the deceased alive on <b>10/3/86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                      |  |   |   |   |                                   |  |  |   |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  |   |   | DEGREE  |                                   |  |  | 22c. DATE SIGNED<br><b>11/3/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |   | 22e. ADDRESS  |                                   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>11-7-1986</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MOSES CEMETERY</b>   |                                   | 23d. LOCATION CITY OR TOWN<br><b>DRURY</b>                             |  | 23e. COUNTY<br><b>ANNA. MARYLAND</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Annnapolis, Md. 21401</b><br><b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 5 1986</b>  |                                   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                       |  |   |  |

BP

023829 NOV-70

00 10 40 N

8.0

WIND SPEED

WIND DIRECTION

WIND DIRECTION

WIND DIRECTION

WIND DIRECTION

WIND DIRECTION



Void Certificate

#86-30421



025767 DEC 1 1986

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 0 4 2 2

REG. NO.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR  |  |
| EFFIE  |  | L   |  | POPE   |  | Nov 27 86 2:30 AM   |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS   |  |
| Female   |  | White   |  | July 19, 1898  |  | 88  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| Maryland   |  | USA   |  |  |  | ANNE ARUNDEL MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Annapolis  |  | Anne Arundel Gen. Hospital  |  | Seamstress   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| Maryland   |  | Anne Arundel  |  | Edgewater  |  | 13e. STREET ADDRESS / ZIP CODE  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.  |  |
| Charles F. Layton, Sr.   |  | Margaret McSherry   |  | No   |  | 212-20-9651   |  |
| 17. INFORMANT ADDRESS  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| Frances Bazzell, Item 13   |  | Respiratory failure   |  | minutes  |  |   |  |
|  |  | metastatic carcinoma  |  | 2 mos  |  |   |  |
|  |  | ed of pancreas  |  | month  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from May 19 75 to 11/27 19 86, that (I) (we) lost saw the deceased alive on 11/26 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  |  |  | 11/28/86  |  |
| William C. Weintraub   |  | 2568 A River Rd - Annapolis, Md. 21401  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |
| Burial   |  | Nov. 29, 1986   |  | Jennings Chapel  |  | Woodbine, Howard, Md.   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |
| Olin L. Molesworth, P.A., Damascus, Md.  |  | DEC 1 1986  |  | Julia Davidson-Randall   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

025267 DE-361

100 27 21 2:30 A

4002

EFFIE

68

July 10, 1960

1000

Female

Virginia

USA

x

Amphibia

Amphibia (Anura)

Geophila

Virginia

Amphibia (Anura)

x

191 June 1960

21 197

Charles

Layton, Jr.

191 June 1960

21 197

10

191 June 1960

191 June 1960

21 197



100 27 21 2:30 A

025267 DE-361

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_  
DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |  |  |                 |  |  |  |      |  |      |  |          |  |
|---|--|---|--|---|--|---|--|--|--|-----------------|--|--|--|------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH  |  |                 |  | MONTH  |  | DAY  |  | YEAR |  | 2b. HOUR |  |
| Charlotte   |  | W   |  | Price   |  | 11 - 27 - 86  |  |  |  | 11              |  | 15   |  | A.M. |  |      |  |          |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS |  |  |  |      |  |      |  |          |  |
| Female  |  | White   |  | 9 29 07   |  | 79 YRS.   |  | MONTHS   |  | DAYS            |  | HOURS  |  | MIN. |  |      |  |          |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |                 |  |  |  |      |  |      |  |          |  |
| PA.   |  | U.S.A.  |  | Anne Arundel County MD.   |  |   |  |  |  |                 |  |  |  |      |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |   |  |  |  |                 |  |  |  |      |  |      |  |          |  |
| Annapolis   |  | Anne Arundel General Hosp.  |  |   |  |   |  |  |  |                 |  |  |  |      |  |      |  |          |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |   |  |  |  |                 |  |  |  |      |  |      |  |          |  |
| Homemaker   |  | Home  |  |   |  |   |  |  |  |                 |  |  |  |      |  |      |  |          |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE   |  |                 |  |  |  |      |  |      |  |          |  |
| MD.   |  | A.A.  |  | Annapolis   |  | NO  |  | 840 Woodmont Dr. 21401   |  |                 |  |  |  |      |  |      |  |          |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |   |  |  |  |                 |  |  |  |      |  |      |  |          |  |
| Arthur G.   |  | Wall  |  | No  |  |   |  |  |  |                 |  |  |  |      |  |      |  |          |  |
| 17a. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  |   |  |   |  |  |  |                 |  |  |  |      |  |      |  |          |  |
| 383-  |  | Thomas Ferguson Smithman, MD.   |  |   |  |   |  |  |  |                 |  |  |  |      |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>GASTRIC CARCINOMA</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____                      |  |   |  |   |  |   |  |  |  |                 |  |  |  |      |  |      |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____  |  |   |  |   |  |   |  |  |  |                 |  |  |  |      |  |      |  |          |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |                 |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |      |  |      |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)   |  |                 |  |  |  |      |  |      |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |                 |  |  |  |      |  |      |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 24</u> , 19 <u>86</u> , to <u>Nov. 27</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Nov 26</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |                 |  |  |  |      |  |      |  |          |  |
| 22b. SIGNATURE  |  |   |  | DEGREE  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |                 |  | 22c. DATE SIGNED   |  |      |  |      |  |          |  |
| A. Caputo, M.D.   |  |   |  |   |  |   |  |  |  |                 |  | 11-27-86   |  |      |  |      |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS  |  |   |  |  |  |                 |  |  |  |      |  |      |  |          |  |
| A. Caputo, M.D.   |  |   |  | 132 Holiday Ct. Annapolis, MD.  |  |   |  |  |  |                 |  |  |  |      |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)  |  |   |  | 23b. DATE   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |      |  |      |  |          |  |
| Burial  |  |   |  | 12/1/86   |  |   |  | Our Mother of Sorrows  |  |                 |  | Greenfield Township PA.  |  |      |  |      |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  |   |  | ADDRESS   |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  |                 |  | 25b. REGISTRAR'S SIGNATURE   |  |      |  |      |  |          |  |
| Taylor Funeral Chapel   |  |   |  | Annapolis, MD.  |  |   |  | DEC 3 1986   |  |                 |  |  |  |      |  |      |  |          |  |

MEDICAL CERTIFICATION

1. The first part of the report is a summary of the work done during the period from 1 January to 31 March 1978. This includes a description of the methods used, the results obtained, and a discussion of the findings.

2. The second part of the report is a detailed account of the work done during the period from 1 April to 31 June 1978. This includes a description of the methods used, the results obtained, and a discussion of the findings.

3. The third part of the report is a detailed account of the work done during the period from 1 July to 31 September 1978. This includes a description of the methods used, the results obtained, and a discussion of the findings.

4. The fourth part of the report is a detailed account of the work done during the period from 1 October to 31 December 1978. This includes a description of the methods used, the results obtained, and a discussion of the findings.

5. The fifth part of the report is a summary of the work done during the period from 1 January to 31 December 1978. This includes a description of the methods used, the results obtained, and a discussion of the findings.



025997 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to the papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 86 30424   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>ARMISTEAD F. RAMSEY</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>NOV 29 86</b>   |  |   |  |
| 3 SEX <b>MALE</b>   |  |   |  | 2b. HOUR <b>M</b>   |  |   |  |
| 4. RACE <b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Jan 24, 1922</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH <b>Annapolis</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1000 Paddington Place</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Owner-Operator</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>music store</b>  |  |
| 13a. STATE <b>MD</b>  |  | 13b. COUNTY <b>AA</b>   |  | 13c. CITY OR TOWN <b>Annapolis</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>John William Ramsey</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Tina Watson</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <b>Yes 1942-1945</b>   |  | 16b. SOCIAL SECURITY NO. <b>230-16-5186</b>   |  |
| 17. INFORMANT <b>Gayle Ramsey</b>   |  | ADDRESS <b>3838 Calvert St, NW</b>  |  | CITY <b>Washington</b>  |  | STATE <b>DC</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ca of Brain stroke/thrombus</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>11/14</b> 19 <b>86</b> , to <b>11/29</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>11/14</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |   |  |   |  |   |  |
| 22b. SIGNATURE <b>Rodney L Brimball MD</b>  |  |   |  | DEGREE <b>MD</b>  |  | 22c. DATE SIGNED <b>12/1/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Rodney L Brimball MD</b>   |  |   |  | 22e. ADDRESS <b>Forest Drive, Annapolis MD</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>  |  | 23b. DATE <b>Dec 1, 1986</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland PG MD</b>   |  |
| 24. FUNERAL DIRECTOR NAME <b>Taylor Funeral Chapel Annapolis, MD</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>DEC 5 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |

BP



TO THE DIRECTOR OF THE BUREAU OF LAND MANAGEMENT  
WASHINGTON, D. C.

RE: [Illegible]

[Illegible handwritten text]

1

[Illegible handwritten text]

[Illegible handwritten text]

025613 DEC - 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 0 4 2 5

REG. NO.

|  |  |  |  |  |                             |  |
|--|--|--|--|--|-----------------------------|--|
| 1. DECEASED NAME<br>FIRST MIDDLE LAST<br><b>Nettie B. Shaw</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 24, 1986</b>  |  | 2b. HOUR<br><b>11:55 AM</b> |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3   18   88</b>   |                             |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>98</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  | IF UNDER 24 HRS.   |                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                             |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>A.A. County</b> MD.   |  |  |  |  |                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Severna Park</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Meridian Nsg. Center</b> |  |                             |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  |  |  |                             |  |
| 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |                             |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE <b>MD</b> 13c. COUNTY <b>Balto.</b> 13d. CITY OR TOWN <b>Balto.</b> 13e. STREET ADDRESS / ZIP CODE<br><b>1700 W. Meridian Dr. 21239</b>   |  |  |  |  |                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James F. Bradburn</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sarah E. Robinson</b>  |  |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217-01-2757</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Gary Shaw 106 Railroad Ave, Pasadena, MD 21122</b>  |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sudden respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>AS CVD</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>organic brain syndrome</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a<br><b>atherosclerosis</b> |  |  |  |  |                             |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                             |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                             |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                             |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a. certify that (I) (this hospital) attended the deceased from <b>July 10, 1986</b> to <b>Nov 15, 1986</b> that (I) (we) last saw the deceased alive on <b>Nov 15, 1986</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                             |  |
| 22b. SIGNATURE<br><b>Mustafa C. Oz MD</b>  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>11 24 86</b>  |                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mustafa C. Oz MD</b>   |  | 22e. ADDRESS<br><b>605 Bat Blvd SP MD 21146</b>  |  |  |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11-29-86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>   |                             |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn, Balto, MD</b>   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>495 RITCHIE HWY. SEVERNA PARK<br/>BARRANCO FUNERAL HOME MD 21146</b>  |  |  |                             |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.

NOV 28 1986

Julia Davidson-Randall

025018 00-00

20% COTTON 3528

WHEELY D DMD

31  
025852 DEC-3 86

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 30420

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CHARLES P SMITH</b> |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 13 86</b> |   |  | 2b. HOUR<br><b>1411 PM</b>  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>FEB 21 1916</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>              |  |
| 10. CITY OR TOWN OF DEATH<br><b>FT. MEADE</b>                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>KIMBROUGH ARMY COMMUNITY HOSP.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Military</b> |  |
| 13a. STATE<br><b>MD</b>  |  |  |  | 13b. COUNTY<br><b>Talbot</b>  |  | 13c. CITY OR TOWN<br><b>Bellevue</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Smith</b>                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rebecca Gotes</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS ZIP CODE<br><b>62 Talbot Village 21601</b>                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b> |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>1944-1971</b>  |  | 17. INFORMANT<br><b>son - Clayton Smith</b>   |  | ADDRESS<br><b>son - Clayton Smith</b>   |  |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>30 min</b> |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary Artery Disease</b>  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Respiratory Failure from bilateral pneumonia</b>   |  |  |
| CONDITIONS, IF ANY, WHICH<br>GAVE RISE TO IMMEDIATE<br>CAUSE (a), STATING THE<br>UNDERLYING CAUSE LAST.   |  |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  
**Chronic Obstructive Pulmonary Disease**

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/12</b> , 19 <b>86</b> , to <b>11/13</b> , 19 <b>86</b> , that (I) (was) last<br>saw the deceased alive on <b>11/13</b> , 19 <b>86</b> , and that in (my) (best) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Mike A. Royle</b>  |  |  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>11/13/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MIKE A. Royle MD</b>  |  |  |  | 22e. ADDRESS<br><b>KIMBROUGH APT MEDICAL CLINIC, FT MEADE, MD 20755</b>        |  |   |  |

|   |  |                              |  |  |  |   |  |
|---|--|------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                |  | 23b. DATE<br><b>11/19/86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. VA Cem.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>New York Kan. MD</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>James H. Washnell Eastern md</b> |  |                              |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 2 - 1986</b>     |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rodgers</b>           |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by a funeral home physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

MEDICAL CERTIFICATION

11 13 14 15

16 17 18 19

20 21 22 23

24 25 26 27

28 29 30 31



1. General Information  
2. General Safety Rules  
3. General Rules for Patient Treatment  
4. General Rules for Laboratory Work  
5. General Rules for Equipment Use  
6. General Rules for Waste Disposal  
7. General Rules for Infection Control  
8. General Rules for Emergency Procedures  
9. General Rules for Record Keeping  
10. General Rules for Quality Assurance

11. General Rules for Patient Privacy  
12. General Rules for Patient Consent  
13. General Rules for Patient Education  
14. General Rules for Patient Assessment  
15. General Rules for Patient Monitoring  
16. General Rules for Patient Documentation  
17. General Rules for Patient Communication  
18. General Rules for Patient Collaboration  
19. General Rules for Patient Evaluation  
20. General Rules for Patient Feedback

21. General Rules for Patient Satisfaction  
22. General Rules for Patient Loyalty  
23. General Rules for Patient Retention  
24. General Rules for Patient Referral  
25. General Rules for Patient Recommendation  
26. General Rules for Patient Advocacy  
27. General Rules for Patient Empowerment  
28. General Rules for Patient Empathy  
29. General Rules for Patient Compassion  
30. General Rules for Patient Kindness

31. General Rules for Patient Respect  
32. General Rules for Patient Dignity  
33. General Rules for Patient Honor  
34. General Rules for Patient Integrity  
35. General Rules for Patient Honesty  
36. General Rules for Patient Truthfulness  
37. General Rules for Patient Accountability  
38. General Rules for Patient Responsibility  
39. General Rules for Patient Commitment  
40. General Rules for Patient Dedication



025996 DEC 4

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 30421

REG. NO.

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>John Thomas Sowers   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 27 86                                |  | 2b. HOUR<br>6:15 AM  |
| 3. SEX<br>Male  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 16 06   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS                                      |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>New York   | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel MD.                       |  |  |
| 10. CITY OR TOWN OF DEATH<br>Crownsville  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Fairfield Nursing Center |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>U.S. gov.  | 12b. KIND OF BUSINESS OR INDUSTRY<br>gov. Ret  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD  |   | 13b. COUNTY<br>A.A.   | 13c. CITY OR TOWN<br>Edgewater   | 13d. INSIDE CITY LIMITS?<br>YES NO <input checked="" type="checkbox"/>               | 13e. STREET ADDRESS / ZIP CODE<br>1443 Shore Dr 21037  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>DANIEL S. SOWERS SR   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>HARRIET CROWDER  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |   | 16b. SOCIAL SECURITY NO.<br>1944-1945 216 44 7524   | 17. INFORMANT<br>ADDRESS<br>Same as<br>ETTA J. SOWERS # 13                     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE Cause (a) Renal Failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (b) Bladder cancer<br>underlying cause (c) Congestive Heart Failure |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Months 11  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2) |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |
| 22a. I certify that (1) this hospital attended the deceased from 19 86, to 11/27 19 86, that (1) (we) last saw the deceased alive on 12/10 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) did (did not) view the body after death.        |   |   |  |  |  |
| 22b. SIGNATURE<br>Joseph F. Enay for Gregory Mitchell<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |   |   |  | 22c. DATE SIGNED<br>11/29/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Gregory Mitchell   |   | 22e. ADDRESS<br>205 Ridgely Ave Annapolis, MD   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK)<br>Burial  | 23b. DATE<br>12/1/86  | 23c. NAME OF CEMETERY OR CREMATORY<br>Crownsville Vet.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Crownsville AA MD.                     |  |
| 24. FUNERAL DIRECTOR<br>TAYLOR FUNERAL CHAPEL   |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 3 1986   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Tindon-Rudace                                    |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 4E state any injury or other traumatic event, the medical examiner should be notified.

BP

052-1-10



MINIATURE

NOTED 5/22/64

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
[The remainder of the text in this section is illegible due to extreme fading.]



025995 DEC 14

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8630428

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HAROLD W. TABLER</b>                                     |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-28-86</b> |   |  | 2b. HOUR<br>P.M.<br><b>6:50</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2-18-1917</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>-69-</b>                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel</b> MD.                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Annapolis Convalescent Center</b>   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Accountant</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b> |  | 13b. COUNTY<br><b>AA</b>  |  | 13c. CITY OR TOWN<br><b>Annapolis</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Oscar Tabler</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Edith Warfield</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>1WWT 578-01-3742</b>   |  |
| 17. INFORMANT<br>NAME ADDRESS<br><b>Alice H. Tabler - #13</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Instantaneous death</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Massive myocardial infarct</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>OR Pulmonary Embolism</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b>  |  |   |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Instantaneous death</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Massive myocardial infarct</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>OR Pulmonary Embolism</b>                               |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b>                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Recent Intracranial Hemorrhage; S.P. Cr. artery bypass surgery -</b>   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                     |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)               |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1980</b> , 19 to <b>Present</b> , 19, that (I) (last saw the deceased alive on <b>11/28/86</b> , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Peter F. Verkouwen MD</b>  |  |  |  | 22c. DATE SIGNED<br><b>11-28-86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PETER F. VERKOUWEN</b>  |  |  |  | 22e. ADDRESS<br><b>1828 Forest Drive, Annapolis, Md 21403</b>                        |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Dec 2, 1986</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>All Hallows Chapel</b>                      |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Davidsonville AA MD</b>  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Taylor Funeral Chapel - Annapolis, MD</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 3 1986</b>                                   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>   |  |  |  |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



025848 DE

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|  |  |  |   |   |
|--|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Beatrice Tingle</b>   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11 23 1986</b>                          |   | 2b. HOUR<br>M <b>0040</b>   |
| 3. SEX<br><b>F</b>   | 4. RACE<br><b>Neg</b>                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>12 24 10</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>75 YRS.</b>   | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>AA</b>  |  | MD.  |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Anne Arundel Gen</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                       |
| 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |   |   |
| 13a. STATE<br><b>md.</b>   |  | 13b. CITY OR TOWN<br><b>Grasonville</b>  |   | 13c. STREET ADDRESS<br><b>Rt 1 Box 753</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>D Henry</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lina Lareman</b>   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>24-164684</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Cecilia Gishov</b>                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last<br>(b) <b>A.S.C.V.D.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I<br><b>Hypertension, Diabetes Mellitus</b>   |  |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)       |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |   |   |
| ACTUAL SIGNATURE<br><b>William P. Jones</b>  |  | TITLE (SPECIFY)<br><b>Deputy</b>   |   | DATE SIGNED<br><b>11/23/86</b>  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  | ADDRESS  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE<br><b>11/29/86</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Robinson Cem</b>   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Grasonville CB MD</b>              |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Joseph A. Galt, Jr. MD</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 2 1986</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                         |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

022040 DEC-300

NOV 30 1960

RECEIVED  
FBI  
NOV 30 1960

U.S. DEPT. OF JUSTICE

RECEIVED  
FBI  
NOV 30 1960

*[Faint, mostly illegible handwritten text, possibly a letter or report, covering the majority of the page.]*

Void Certificate

#86-30430



025937 DEC 13 1986

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 3 0 4 3 1  
REG. NO. EST

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HARRY J VEDRAL SR</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 30, 1986</b>   |  | 2b. HOUR<br><b>705 PM</b>  |  |
| 3 SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 26, 1915</b>                               |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS   |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b>  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Auto Mechanic</b> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>  |  | 13a. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13b. STREET ADDRESS / ZIP CODE<br><b>592 Park Road 21146</b>                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Vedral</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Jenny Fleishman</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II 216-03-9739</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Irma W. Vedral, Same as 13</b>                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Shock.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Compensated fibril</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute myocardial infarct</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Hours. Days. 17/24/86.</b> |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 1a  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11/30 82</b>                       |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (I) (this hospital) attended the deceased from <b>11/24</b> , 19 <b>82</b> , to <b>11/30</b> , 19 <b>86</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/30</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death. |  | 22b. SIGNATURE<br><b>Gerald Church</b> M.D.  |  |
| 22c. DATE SIGNED<br><b>12/1/82</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GERALD CHURCH, M.D.</b>   |  | 22e. ADDRESS<br><b>8 EVERGREEN ROAD SEVERNA PARK, MARYLAND 21146</b>                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>Dec. 2, 1986</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Security Process, Inc.</b>                      |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Catonsville Baltimore MD</b>  |  | 24. FUNERAL DIRECTOR<br>NAME<br><b>James S. Kirkley, Glen Burnie, MD</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 2 1986</b>                                       |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain portions. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



2003 OCT 30

15 202 000 10 100 702 81

THE AMERICAN

WORTH A BRIGHT FUTURE

THE AMERICAN

2003 OCT 30

MINI

1. MICHIGAN

2. MICHIGAN

3. MICHIGAN

2003 OCT 30

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Hazel

J.

Wilson

2a. DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 19 2b. HOUR M

3. SEX Female

4. RACE Can

5. DATE OF BIRTH MONTH DAY YEAR 5 12 09

6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.

IF UNDER 1 YR. MONTHS DAYS

IF UNDER 24 HRS. HOURS MIN.

7c. DATE PRONOUNCED DEAD 11 26 86 19 2d. HOUR M 1945

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana

7b. CITIZEN OF WHAT COUNTRY? U. S. A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH A A MD

10. CITY OR TOWN OF DEATH Glen Burnie

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager

12b. KIND OF BUSINESS OR INDUSTRY Banking

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE Md

13b. CITY OR TOWN A A

13c. CITY OR TOWN Glen Burnie

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS 2106 7900 Benesch Cir #231

14. FATHER'S NAME FIRST MIDDLE LAST Charles Harrison

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Alice Evans

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No

16b. SOCIAL SECURITY NO. 377-24-7827

17. INFORMANT ADDRESS Sue Reschke 1206 Staley Ave., Frederick, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebrovascular Accident

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

William P. Jones, M.D.

TITLE (SPECIFY)

Deputy

MEDICAL EXAMINER

DATE SIGNED

11-27-86

EXAMINER'S NAME (TYPE OR PRINT)

William P. Jones, M.D.

ADDRESS 695 America Crt., Davidsonville, Md. 21035

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

12-2-86

23c. NAME OF CEMETERY OR CREMATORY

White Chapel Memorial

23d. LOCATION CITY OR TOWN

Troy,

Oakland, Michigan

24. FUNERAL DIRECTOR

NAME

MARKULLO FUNERAL SERVICE

ADDRESS

UPPERCO, MD

25a. DATE REC'D. BY REGISTRAR

DEC 1 1986

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

Handwritten text, mostly illegible due to fading and bleed-through. Some words like "The" and "and" are visible.



Handwritten text, mostly illegible due to fading and bleed-through. Some words like "The" and "and" are visible.

025961 DEC 13 1986

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 30433

REG. NO. EST

|  |  |  |  |   |  |  |   |  |   |  |
|--|--|--|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>BLANCHE MARIE WISE</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 30 1986</b>                   |   |  | 2b. HOUR<br>EST<br><b>3:02 AM</b>  |   |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 6, 1919</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN.<br><b>67</b>  |   | 7. UNDER 1 YEAR IF UNDER 24 HRS.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Manager</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Drug Store</b>   |   |  |
| 13a. STATE<br><b>Maryland</b>  |  |  |  |   | 13b. COUNTY<br><b>Anne Arundel</b>   |  | 13c. CITY OR TOWN<br><b>Glen Burnie</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Clarence Ewing</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Blanche M. Simmons</b>           |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No N/A</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>213-28-4887</b>                                   |   | 17. INFORMANT (Son)<br>ADDRESS<br><b>Mr. Louis O. Wise, Jr. Baltimore, Md. 21228</b> |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest &amp; Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Intermittent Embolism</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                 |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11:14 19 86</b>            |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)           |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-14-86</b> to <b>11-29-86</b> , that (I) (we) last saw the deceased alive on <b>11-29-86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |  |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Chackumkal V. Cyriac</b>  |  |  | DEGREE<br><b>MD</b>  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/><br>DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>11-30-86</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHACKUMKAL V. CYRIAC, M.D.</b>   |  |  | 22e. ADDRESS<br><b>14 WELHAM AVE. SUITE 101<br/>GLEN BURNIE, MARYLAND. 21061</b> |   |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>December 3, 1986</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Park</b>   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie, A.A. Maryland</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>R. A. Hopkins</b>   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 2 1986</b>                                   |  |   |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |   |  |  |   |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use on the burial-transit permit. Their please remove carbon papers. Pages 1-3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

CLUB DOGAL, NEWYARD, 21001  
14 WILLIAM AVE, SUITE 101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 0 4 3 4

REG. NO.

|   |  |   |  |  |                               |  |
|---|--|---|--|--|-------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Joseph J. Palumbo</i>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>11 07 86</i> |  | 2b. HOUR<br>M<br><i>225 P</i> |  |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>09/07/06</i>                                      |                               |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>80</i> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS   |  | 8. IF UNDER 24 HRS<br>HOURS MIN.   |                               |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Pennsylvania</i>  |  | 9b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 9c. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Anne Arundel</i> MD.                           |                               |  |
| 10. CITY OR TOWN OF DEATH<br><i>Annapolis</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Anne Arundel General Hospital</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Carpenter -Ret.</i> |                               |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Building</i>  |  | 13a. STATE<br><i>MD</i>   |  | 13b. COUNTY<br><i>A.A.</i>   |                               |  |
| 13c. CITY OR TOWN<br><i>Glen Burnie</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br><i>401 Joyce Dr. 21061</i>                               |                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Joseph Palumbo</i>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Antoinette Visciano</i>   |  |  |                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>no</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>203-01-7347</i>  |  | 17. INFORMANT<br>ADDRESS<br><i>Joseph M. Palumbo, Same as 13</i>                           |                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Metastatic CA Carcinoma of Bladder</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1 year</i> |  |   |  |  |                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |                               |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |                               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)              |                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10/29</i> , 19 <i>86</i> , to <i>11/7</i> , 19 <i>86</i> , that (I) (we) lost<br>saw the deceased alive on <i>11/7</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |                               |  |
| 22b. SIGNATURE<br><i>R.I. Hochman, MD</i>   |  | DEGREE<br><i>MD</i>   |  | 22c. DATE SIGNED<br><i>11/7/86</i>   |                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>R.I. Hochman, MD</i>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22e. ADDRESS<br><i>16 Murray Ave, Annapolis, MD 21406</i>                                  |                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>12 Nov. 86</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Meadowridge Mem. Pk.</i>                          |                               |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Dorsey Howard MD</i>   |  | 23e. DATE RECEIVED BY REGISTRAR<br><i>NOV 10 1986</i>   |  | 23f. REGISTRAR'S SIGNATURE<br><i>James S. Kirkley</i>                                      |                               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>James S. Kirkley Glen Burnie, MD 21061</i>   |  |   |  |  |                               |  |

025373 13 09

BOX COLLECTIBLES

FILE IN BOX



023676 NOV 12 1986

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 0 4 3 5

REG. NO.

EDT

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(OR PRINT) FIRST MIDDLE LAST<br><b>KENNETH WAYNE PHILLIPS</b>                             |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 08, 1986</b>                            |  | 2b. HOUR<br><b>1036 AM</b>                               |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Sept. 28, 1939</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.<br><b>47</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Product Mgr.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Security Co.</b> |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>A.A.</b>  | 13c. CITY OR TOWN<br><b>Glen Burnie</b>                                  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Herbert R. Phillips</b>   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Lillian R. Bush</b>                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b> |  | 16b. SOCIAL SECURITY NO.<br><b>218-36-9940</b>  |   | 17. INFORMANT ADDRESS<br><b>Florence Phillips (same as 13e)</b>          |  |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

|   |   |  |  |
|---|---|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |  |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |  |  |
| 22b. SIGNATURE <b>Basant K. Khandelwal</b> DEGREE <b>M.D.</b>   |   | 22c. DATE SIGNED <b>11/8/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BASANT K. KHADELWAL M.D.</b>  |   | 22e. ADDRESS<br><b>7422 BALTIMORE ANNAPOLIS BOULEVAR GLEN BURNIE, MARYLAND 21061</b> |  |

|   |                              |  |  |
|---|------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                            | 23b. DATE<br><b>11/12/86</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Men. Pk.</b> | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Glen Burnie, A.A.Co., Maryland</b> |
| 24. FUNERAL DIRECTOR<br><b>George J. Gonce, 4001 Ritchie Hwy., Baltimore, (21225)</b> |                              | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 10 1986</b>              | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                      |

09870 10.15.13

POSTED BY: MR. J. H. WHITE

RECEIVED BY: MR. J. H. WHITE

NAME: JAMES WHITE

NAME: JAMES WHITE

NAME: JAMES WHITE

1

RECEIVED BY: MR. J. H. WHITE

RECEIVED BY: MR. J. H. WHITE

RECEIVED BY: MR. J. H. WHITE

RECEIVED BY: MR. J. H. WHITE

RECEIVED BY: MR. J. H. WHITE

025369

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8630436

REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Mary Alice Rapp   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 22, 1986                      |  | 2b. HOUR<br>M  |
| 3. SEX<br>Female  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>September 11, 1907  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN. |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel Co. MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Linthicum  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>906 Wanda Road |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>(Retired) |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>C & P Telephone   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |   |   | 13b. COUNTY<br>A A Co.  | 13c. CITY OR TOWN<br>Linthicum   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Walter J. Crane   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Jane Boyce              |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>NA   |   | 17. INFORMANT (Husband) ADDRESS<br>Mr. John C. Rapp Same as #13  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Cardiovascular disease.</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                         |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/12</u> 19 <u>86</u> to <u>11/22</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>11/11</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |   |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u>  |   | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>11/24/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SURYA P. MUNDRA MD   |   | 22e. ADDRESS<br>203 E PATAPSCO AV BALTIMORE MD 21221  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |   | 23b. DATE<br>Nov 26, 1986   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Park  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Elkridge Howard Md.   |   | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Singleton Funeral Home Glen Burnie, Maryland  |   |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br>NOV 26 1986  |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

1934



MADE IN U.S.A. 100% COTTON

WOMEN'S WEAR

MADE IN U.S.A. 100% COTTON

23743 NOV 13 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <u>JEAN</u> MIDDLE <u>III</u> LAST <u>RAVITZ</u>   |  |   | 2a. DATE OF DEATH<br>KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/><br>MONTH <u>11</u> DAY <u>4</u> YEAR <u>1986</u> |   |  | 2b. HOUR<br>M <u>1539</u>  |  |  |  |  |
| 3. SEX<br><u>FEMALE</u>   |  | 4. RACE<br><u>CAU</u>                     |  | 5. DATE OF BIRTH<br>MONTH <u>1</u> DAY <u>23</u> YEAR <u>12</u>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <u>74</u> YRS.  |  | 7. IF UNDER 1 YR.<br>MONTHS <u>  </u> DAYS <u>  </u> HOURS <u>  </u> MIN. <u>  </u>  |  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>MARYLAND</u>   |  | 9. CITIZEN OF WHAT COUNTRY?<br><u>USA</u> |  | 10. EVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><u>ANNE ARUNDEL CO.</u>   |  |  |  |  |
| 12. CITY OR TOWN OF DEATH<br><u>Glen Burnie</u>   |  |   | 13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>North Arundel</u>                 |   |  | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>GEN. HOSP. HOUSEWIFE</u>                          |  |  | 15. KIND OF BUSINESS OR INDUSTRY<br><u>AT HOME</u> |  |
| 16. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE <u>Md.</u> COUNTY <u>BALTO</u> CITY OR TOWN <u>BALTO</u>  |  |   | 17. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |  | 18. STREET ADDRESS<br><u>APT. C-2 #21215</u><br><u>5901 Doverdale RD.</u>  |  |  |  |  |
| 19. FATHER'S NAME<br>FIRST <u>HYMAN</u> MIDDLE <u>  </u> LAST <u>PRESS</u>  |  |   | 20. MOTHER'S MAIDEN NAME<br>FIRST <u>ETHEL</u> MIDDLE <u>  </u> LAST <u>FOX</u>  |   |  | 21. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <u>NO</u> (IF YES, GIVE WAR OR DATES) <u>  </u> |  |  |  |  |
| 22. SOCIAL SECURITY NO.<br><u>214-22-8909</u>   |  |   | 23. INFORMANT<br><u>IRWIN RAVITZ PRESS APT. C-2</u><br><u>5901 DOVERDALE RD. BALTO., MD 21215</u>  |   |  |  |  |  |  |  |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). <u>Cardiopulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <u>ASCVD.</u><br>(b). <u>  </u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c). <u>  </u>   |  |   |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><u>Hypertension</u>  |  |   |  |   |  |  |  |  |  |  |
| 25. DATE OF OPERATION<br><u>  </u>  |  |   | 26. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><u>  </u>  |   |  |  |  | 27. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |
| 28. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   | 29. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>  </u> P.M. <u>  </u> <u>19</u>   |   |  | 30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><u>  </u>                            |  |  |  |  |
| 31. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |   | 32. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><u>  </u>  |   |  | 33. LOCATION<br>STREET <u>  </u> CITY OR TOWN <u>  </u> COUNTY <u>  </u> STATE <u>  </u>                             |  |  |  |  |
| 34. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |  |   |  |  |  |  |  |  |
| 35. ACTUAL SIGNATURE<br><u>William P. Jones</u>   |  |   | 36. TITLE (SPECIFY)<br><u>M.D. Deputy</u>  |   |  | 37. MEDICAL EXAMINER   |  |  | 38. DATE SIGNED<br><u>4 Nov 86</u>                 |  |
| 39. EXAMINER'S NAME (TYPE OR PRINT)<br><u>William P. Jones, M.D.</u>  |  |   | 40. ADDRESS<br><u>695 America Crt. Davidsonville, Md 21035</u>   |   |  |  |  |  |  |  |
| 41. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>BURIAL</u>   |  |   | 42. DATE<br><u>NOV. 6, 1986</u>  |   | 43. NAME OF CEMETERY OR CREMATORY<br><u>CHIZUK AMUNO</u> |  |  | 44. LOCATION<br>CITY OR TOWN <u>BALTIMORE</u> COUNTY <u>  </u> STATE <u>MARYLAND</u> |  |  |
| 45. FUNERAL DIRECTOR<br>NAME <u>SOL LEVINSON &amp; BROS., INC.</u><br>ADDRESS <u>6010 REISTERSTOWN RD. BALTO., MD 21215</u>   |  |   |  |   |  | 46. DATE REC'D. BY REGISTRAR<br><u>NOV 10 1986</u>   |  | 47. REGISTRAR'S SIGNATURE<br><u>Julia Benson-Kendall</u>                             |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

RAVAT

Year

1951

Mr. RAVAT



1951

1951

1951

025936 DEC-3 1986

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. EST

|   |  |   |   |   |                           |  |
|---|--|---|---|---|---------------------------|--|
| 1. DECEASED NAME<br>(PRINT NAME)<br>FIRST MIDDLE LAST<br><b>DOMENECK L. REINHARDT</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 28, 1986</b> |   | 2b. HOUR<br><b>511 AM</b> |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>September 24, 1902</b>   |                           |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b>  |  | 7. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                           |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Louisiana</b>   |  | 9b. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>   |   | 10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |                           |  |
| 11. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>   |  | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |   | 13. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |                           |  |
| 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>A.A.</b>  |   | 13c. CITY OR TOWN<br><b>Glen Burnie</b>   |                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Luiaco</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rose Marino</b>   |   | 16. STREET ADDRESS / ZIP CODE<br><b>104 Queen Anne Rd. 21061</b>  |                           |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>no</b>  |  | 17b. SOCIAL SECURITY NO.<br><b>213-09-6769</b>  |   | 17. INFORMANT<br><b>John Reinhardt</b><br>ADDRESS<br><b>P.O. Box 869 Pasadena, MD 21122</b>   |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>A.S.C.V. H.D.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____      |  |   |   |   |                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |   |   |                           |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                           |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 1985</b> to <b>Nov 28, 1986</b> , that (I) (we) lost saw the deceased alive on <b>Oct 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |  |   |   |   |                           |  |
| 22b. SIGNATURE<br><b>Benito Martinez</b>  |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED  |                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BENITO MARTINEZ, M.D.</b>   |  | 22e. ADDRESS<br><b>2932-A MOUNTAIN ROAD PASADENA, MARYLAND 21122</b>  |   | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>             |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1 Dec. 86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Pk.</b>  |                           |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>James S. Kirkley</b>   |  | ADDRESS<br><b>Glen Burnie, MD 21061</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 2 1986</b>  |                           |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |   |   |                           |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon (page 3) and 7 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1, then any injury, or other traumatic event, must be noted on page 4.





024541 NOV 20 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 22 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

EST

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>GROVER C RICHARDS JR</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 17, 1986</b> |   |  | 2b. HOUR<br><b>212 PM</b>   |   |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>5 22 11</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MINUTES<br><b>75 YRS.</b>   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>  |   |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>dispatcher</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>trucking</b>  |   |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>A.A.</b>  |  | 13c. CITY OR TOWN<br><b>Glen Burnie</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |   |
| 13e. STREET ADDRESS / ZIP CODE<br><b>Apt. 102 7906 Allard Ct. 21061</b>   |  | 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Grover Cleveland Richards</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Amelia Baer</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218 10 1443</b>  |  | 17. INFORMANT ADDRESS<br><b>Madeline K. Richards (same as 13E)</b>  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Extensive Bowel resection for gangrene</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hour</b><br><b>3 years</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |   |  |   |   |
| 19a. DATE OF OPERATION<br><b>12-15</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>84</b>   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE<br><b>STREET</b>  |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-15</b> , 19 <b>84</b> , to <b>8-5</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>8-5</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |   |
| 22b. SIGNATURE<br><b>Long S. HSU</b>  |  | DEGREE<br><b>MD.</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>11-19-86</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HSU, LONG S., M.D.</b>  |  | 22e. ADDRESS<br><b>7845 OAKWOOD ROAD GLEN BURNIE, MARYLAND 21061</b>  |  |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>burial</b>  |  | 23b. DATE<br><b>11/20/86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Glen Burnie A.A. Md.</b>  |   |
| 24. FUNERAL DIRECTOR NAME<br><b>George Gonce</b>  |  | ADDRESS<br><b>4001 Ritchie Hwy. Baltimore Md. 21225</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |   |

BP

02-11-1980

NOVEMBER 17, 1980 2:15 PM

RECEIVED

CLIN

ADAMS COUNTY

NORTH AMHERST HOSPITAL

CLIN

1000-1111-1111

3 years  
3 years

Extensive work record for 3 years

11-12-80 8-2-80 11-12-80

11-12-80

CLIN BIRNIE, MARILYN STOR

CLIN BIRNIE, MARILYN STOR

NOV 19 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove this page. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 0 4 4 0

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| 1- FOR STATE REGISTRAR  |   | REG. NO.  |  | EST  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>HULDAH M. RING   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>NOVEMBER 12, 1986                    |  | 2b. HOUR<br>9:55 A M                         |
| 3 SEX<br>FEMALE   | 4. RACE<br>CAUCASIAN  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 22 06  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS<br>IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>MARYLAND   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ANNE ARUNDEL COUNTY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>GLEN BURNIE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NORTH ARUNDEL HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Cook | 12b. KIND OF BUSINESS OR INDUSTRY<br>Local Govt  |  |
| 13a. STATE<br>Maryland  |   | 13b. COUNTY<br>A A  | 13c. CITY OR TOWN<br>Glen Burnie   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>UNKNOWN   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNKNOWN  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>221 07 9906  |  | 17. INFORMANT<br>Glen Burnie, Md 21061 Apt 172A<br>Michael Ring 6642 Whitmore Ct.                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiorespiratory arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Congestive Heart Failure, Renal Failure Cerebrovascular accident |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                    |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |  |  |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |   |   |  |  |  |
| 22b. SIGNATURE<br>Basant K. Khandelwal  |   | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br>11/12/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BASANT K. KHADELWAL, M.D.  |   | 22e. ADDRESS<br>7422 Baltimore-Annapolis Blvd.<br>Glen Burnie, Maryland 21061   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   | 23b. DATE<br>11/13/86   | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Park   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville Balto Md   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Raymond C. Fink   |   | Glen Burnie, Md. 21061  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 13 1986   |  |
|   |   | 25b. REGISTRAR'S SIGNATURE<br>Julia Decker-Randall  |  |  |  |

BP

753074

PLATE 1

— — —

11. 6. 2006

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 should be detached for use as the burial-transit permit. Then please remove the chain of papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |   |  |
|--|--|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR   |  | 2b. HOUR  |  | M   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST   |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR  |  | 2b. HOUR  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR   |  |
| FEMALE   |  | Cau.  |  | 2-26-05  |  | 8L  |  | MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  | 10. CITY OR TOWN OF DEATH   |  |
| Baltimore Md.  |  | U.S.A.  |  |  |  | Anne Arundel Co.  |  | Annapolis   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)             |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  | 13a. STATE  |  | 13b. COUNTY   |  |
| Anne Arundel Gen. Hosp.  |  | housewife   |  | household  |  | Md.   |  | A.A. Co.  |  |
| 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE   |  | 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  |
| Annapolis  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |  | 1110 West St. 21401  |  | Benjamin Friedman   |  | Frieda Farbman  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                              |  |
| no   |  | 220-60-9236   |  | Jeff Kahn 4619 Brandywine St. N.W. Wash. D.C.  |  | Ruptured diverticulum   |  | 1 mos   |  |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) |  | 21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | 22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) |  |
| IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF  |  | DUE TO, OR AS A CONSEQUENCE OF   |  | DUE TO, OR AS A CONSEQUENCE OF  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  | (b)   |  | (c)  |  | (d)   |  | (e)   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                       |  | COPD  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                          |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  |  |   |  |
|  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)       |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |  | 21d. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |
|  |  | P.M. 19   |  |  |  |   |  |   |  |
| 21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |  | 21f. PLACE OF INJURY (ATHOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |  | 21g. LOCATION CITY OR TOWN COUNTY STATE  |  | 21h. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |
|  |  |   |  |  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from   |  | 10/10 19 86   |  | to 11/9 19 86  |  | that (I) (we) lost saw the deceased alive on 11/9 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |
| 22b. SIGNATURE   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED  |  |   |  |
| Stuart E. Selouch, MD  |  |   |  |  |  | 11/9/86   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| Stuart E. Selouch, MD  |  | 51 Franklin St Annapolis, Md. 21014                                       |  | Burial   |  | 11/11/86  |  | Kneseth Isreal Cem.   |  |
| 24. FUNERAL DIRECTOR NAME  |  | 24a. DATE REC'D. BY REGISTRAR   |  | 24b. REGISTRAR'S SIGNATURE   |  | 24c. DATE REC'D. BY REGISTRAR   |  | 24d. REGISTRAR'S SIGNATURE  |  |
| HARDESTY FUNERAL HOME 12 RIDGELY AVE ANN, MD.  |  | NOV 12 1986   |  | Julia Dandrea-Randall  |  | NOV 12 1986   |  |   |  |

BP

058780

11-11-54

11-11-54

11-11-54

11-11-54

11-11-54

11-11-54

11-11-54

11-11-54

11-11-54

11-11-54

11-11-54

11-11-54

11-11-54

11-11-54

11-11-54

11-11-54

11-11-54

11-11-54

11-11-54

11-11-54

11-11-54

11-11-54

11-11-54



024816 NOV 24 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 30442  
REG. NO.

|   |  |   |   |   |                            |   |   |
|---|--|---|---|---|----------------------------|---|---|
| 1. DECEASED NAME<br>FIRST <u>Clytie</u> MIDDLE <u>S. Stacy</u> LAST <u>Rogers</u>   |  |   | 2a. DATE OF DEATH<br>MONTH <u>11</u> DAY <u>17</u> YEAR <u>1986</u> |   | 2b. HOUR<br><u>4:30 AM</u> |   |   |
| 3. SEX<br><u>Female</u>   |  | 4. RACE<br><u>White</u>   |   | 5. DATE OF BIRTH<br>MONTH <u>3</u> DAY <u>27</u> YEAR <u>11</u>   |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>75</u> YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>West Virginia</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>A.A. Co.</u> MD.   |   |
| 10. CITY OR TOWN OF DEATH<br><u>Annapolis</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Anne Arundel Hospital</u> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Factory worker</u>   |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Airlines</u>  |   |
| 13a. USUAL RESIDENCE<br>STATE <u>Maryland</u> COUNTY <u>N. Q.A.</u>   |  | 13b. CITY OR TOWN<br><u>Stevensville</u>  |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                            | 13e. STREET ADDRESS / ZIP CODE<br><u>123 Somerset Rd. 21666</u>   |   |
| 14. FATHER'S NAME<br>FIRST <u>Adam</u> MIDDLE <u>Stacy</u> LAST   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>Mintie</u> MIDDLE <u>Baldwin</u> LAST  |                            |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <u>No</u>  |  | 16b. SOCIAL SECURITY NO.<br><u>236-30-0732A</u>   |   | 17. INFORMANT<br>ADDRESS <u>Stevensville, MD</u><br><u>James A. Rogers, 123 Somerset Rd., 21666</u>   |                            |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CVA</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>IDDm</u> |  |   |   |   |                            |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION<br><u>11/13/86</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>ASCVD</u>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                            | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>11/13/86</u>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |                            |   |   |
| 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/13/86</u> , 19 <u>86</u> , to <u>11/17/86</u> , 19 <u>86</u> , that (I) (we) lost<br>saw the deceased alive on <u>11/16</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |                            |   |   |
| 22b. SIGNATURE<br><u>ERROL A. Phillip</u>   |  |   |   | 22c. DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |                            | 22d. DATE<br><u>11/17/86</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <u>Burial</u>  |  |   |   | 23b. DATE<br><u>11-20-86</u>  |                            | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill Cemetery</u>  |   |
| 24. FUNERAL DIRECTOR<br>NAME <u>Tom Helfenbein Funeral Homes, Chester, MD 21619</u>   |  |   |   | 25a. DATE RECEIVED BY REGISTRAR <u>NOV 21 1986</u>  |                            |   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body. A medical examiner may be retained to examine the body if item 18 shows any injury, or other trauma.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, a medical examiner must be retained to examine the body.

024810 NOV 24 02

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1, 2 and 3 and file them with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

DHMH - 16 60M 7/B4  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REG. NO. 86 30443   |  |
|---|--|--|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH   |  |
| DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Adeline R. RUBINS  |  |  |  |  |  |  |  |  |  | MONTH DAY YEAR<br>Nov 8, 86   |  |
| 1. SEX FEMALE 4. RACE WHITE 5. DATE OF BIRTH MONTH DAY YEAR<br>July 31, 1906  |  |  |  |  |  |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 80  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina 7b. CITIZEN OF WHAT COUNTRY? USA   |  |  |  |  |  |  |  |  |  | 8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  |  |
| 9. BACIMORE CITY OR COUNTY OF DEATH ANNAPOLIS MD.   |  |  |  |  |  |  |  |  |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. CITY OR TOWN 13c. STREET ADDRESS / ZIP CODE   |  |  |  |  |  |  |  |  |  | 14. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 15. FATHER'S NAME FIRST MIDDLE LAST Ransom Riggs 16. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katie L. Schmitt  |  |  |  |  |  |  |  |  |  | 17. ADDRESS 109 Lafayette Ave   |  |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) NO 18b. SOCIAL SECURITY NO. 214-46-2492 19. INFORMANT Thomas R. Rubins-Annapolis, MD 21401  |  |  |  |  |  |  |  |  |  | 20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) cardiac arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) CA Ovary<br>DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10   |  |  |  |  |  |  |  |  |  |   |  |
| 21a. DATE OF OPERATION 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED 21c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                         |  |  |  |  |  |  |  |  |  |   |  |
| 22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 22b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 22c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                    |  |  |  |  |  |  |  |  |  |   |  |
| 23a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK 23b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PUBLIC) 23c. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  |   |  |
| 24a. I certify that (I) (this hospital) attended the deceased from this year 1986, to 1986, that (we) last saw the deceased alive on last month, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |   |  |
| 25a. SIGNATURE William G. Dabbs, M.D. 25b. DEGREE 25c. DATE SIGNED 11/8/84  |  |  |  |  |  |  |  |  |  |   |  |
| 26a. PHYSICIAN'S NAME (TYPE OR PRINT) DABBS, W.A. 26b. ADDRESS 203 GIDDINGS AVE   |  |  |  |  |  |  |  |  |  |   |  |
| 27a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation 27b. DATE Nov. 19, 1986 27c. NAME OF CEMETERY OR CREMATORY Cedar Hill 27d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG. MD   |  |  |  |  |  |  |  |  |  |   |  |
| 28a. FUNERAL DIRECTOR NAME ADDRESS Taylor Funeral Chapel-Annapolis, MD 28b. DATE REC'D. BY REGISTRAR NOV 14 1986 28c. REGISTRAR'S SIGNATURE Julia Davidson-Randall  |  |  |  |  |  |  |  |  |  |   |  |

05430-101010

05430-101010

05430-101010

05430-101010

05430-101010

05430-101010

05430-101010

05430-101010

05430-101010

05430-101010

05430-101010

05430-101010

05430-101010

05430-101010

05430-101010

05430-101010

05430-101010

05430-101010

05430-101010

05430-101010

05430-101010

05430-101010

05430-101010

00-23080

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, and completely fill in by the funeral director, page 3 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |   |  |  |   |   |   | 8630444 |
|---|--|---|---|---|--|--|---|---|---|---------|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   | REG. NO. EDT  |   |  |  |   |   |   |         |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | FIRST<br>ARNOLD   | MIDDLE<br>CLARKE  | LAST<br>SALINGER                                 | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov. 3, 1986  |   |   | 2b. HOUR<br>0300 P.M.                                     |         |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 15 1922   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |         |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Massachusetts  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ANNE ARUNDEL COUNTY MD.  |   |   |   |         |
| 10. CITY OR TOWN OF DEATH<br>Glen Burnie  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NORTH ARUNDEL HOSPITAL |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Asst. Chief Div. of Microbiology                                       |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>State Health Dept.   |   |         |
| 13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>A A Co.  |   | 13c. CITY OR TOWN<br>Glen Burnie                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br>511 Dogwood Drive 21061 |         |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Carl S. Salinger  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Myra E. Clark  |   |  |  |   |   |   |         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII |   | 17. INFORMANT (Wife)<br>Mrs. Mildred W. Salinger |  | ADDRESS<br>Same as #13  |   |   |         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiac arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>hypertension</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic heart disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>sudden</u><br><u>six years</u><br><u>ten yrs.</u> |  |   |   |   |  |  |   |   |   |         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>N/A</u>   |  |   |   |   |  |  |   |   |   |         |
| 19a. DATE OF OPERATION<br><u>N/A</u>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>N/A</u>  |   |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |         |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br><u>N/A</u>   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>N/A</u>   |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><u>N/A</u>   |  |  |   |   |   |         |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/><br><u>N/A</u>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><u>N/A</u>  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><u>N/A</u>   |  |  |   |   |   |         |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 28</u> , 19 <u>50</u> , to <u>Oct 28</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Oct 28</u> , 19 <u>86</u> and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |   |   |   |         |
| 22b. SIGNATURE<br><u>Hilbert P. Manuzak M.D.</u>  |  |   |   | DEGREE<br>M.D.  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><u>Nov 4, 1986</u>  |   |         |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>HILBERT MANUZAK, M.D.</u>   |  |   |   | 22e. ADDRESS<br><u>7575 RITCHIE HIGHWAY SOUTH EAST<br/>GLEN BURNIE, MARYLAND 21061</u>  |  |  |   |   |   |         |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  |  | 23b. DATE<br><u>Nov 6, 1986</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Baldwin Mem. Un. Meth. Church Cemetery</u>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Millersville A A Co. Md.</u>  |   |   |   |         |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>H. H. H. H.</u>  |  |   |   | 25a. DATE RECEIVED BY REGISTRAR<br><u>NOV 5 1986</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |   |   |   |         |

00-29090

SAVINGS BANK

1947

WEST VIRGINIA COUNTY

3x years

1947

1947

1947

023507 NOV 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 30445

REG. NO.

|   |  |   |  |   |  |  |  |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MINNIE STELLA SARGEANT</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>3</b> YEAR <b>86</b> |   |  | 2b. HOUR<br><b>5<sup>30</sup></b> <b>A</b> M   |  |  |  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>19</b> YEAR <b>1896</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>   |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel</b> MD.                      |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Anne Arundel General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b> |  |  |  |
| 13a. STATE<br><b>MD</b>   |  |   |  | 13b. COUNTY<br><b>A.A.</b>  |  | 13c. CITY OR TOWN<br><b>Annapolis</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>825 Bay Ridge Avenue 21403</b>  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Louis</b> MIDDLE <b>Langobr</b> LAST <b>Langobr</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mary</b> MIDDLE <b>Weimer</b> LAST <b>Weimer</b>   |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>579440703</b>  |  |   |  | 17. INFORMANT<br><b>Mabel Patterson</b>   |  |  |  | ADDRESS <b>Same as #13</b>   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.   |  |   |  |   |  |  |  |  |  |  |  |  |
| 9a. DATE OF OPERATION   |  |   |  | 9b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 9c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 9d. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>H. Gold</b>  |  |   |  | DEGREE  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/4/86</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Howard D Goldstein</b>  |  |   |  | 22e. ADDRESS<br><b>205 Ridgely Ave, Annapolis, MD</b>   |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(PRECISE)<br><b>Burial</b>   |  |   |  | 23b. DATE<br><b>Nov. 5, 1986</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Mary's</b>                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Annapolis A.A. MD</b>   |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Taylor Funeral Chapel - Annapolis, MD</b>  |  |   |  | ADDRESS   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV - 6 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Gordon-Randall</b>  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, use in any injury, or other traumatic event, the medical examiner must be notified at once.

BP



BOX COLLUM-FIBER  
 (34) FIBER IN ROW

FIBER IN ROW

FIBER IN ROW

FIBER IN ROW

FIBER IN ROW

FIBER IN ROW

FIBER IN ROW

FIBER IN ROW

FIBER IN ROW

FIBER IN ROW

FIBER IN ROW

FIBER IN ROW

FIBER IN ROW

FIBER IN ROW

FIBER IN ROW

FIBER IN ROW

FIBER IN ROW

FIBER IN ROW

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 21b, then any injury, or other traumatic event, the death certificate must be completed at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 8630446  |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  |
| 7. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Catherine B. Scarano  |  |   |  | 2b. HOUR<br>Nov. 19 1986 3:30 AM  |  |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>5 5 1923   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>63  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Washington, D.C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Laurel   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>49 S Bruce Street |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Sales Person   |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>A.A.   |  | 13c. CITY OR TOWN<br>Laurel   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Truxton  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Dorothy Miller  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN) <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES) <input type="checkbox"/>       |  |   |  |
| 16b. SOCIAL SECURITY NO.<br>579-22-3656   |  | 17. INFORMANT ADDRESS<br>Charles M. Scarano same as 13c   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO VES. RADY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC LUNG CANCER WITH</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>BRAIN METASTASIS ; ABDOMINAL METASTASIS</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>COPD</u> |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION<br>-   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>-   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6. 13.</u> 19 <u>86</u> , to <u>11. 18</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>10. 9.</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |
| 22b. SIGNATURE <u>Christine deLima</u> DEGREE   |  |   |  | 22c. DATE SIGNED<br>11/19/86  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Christine deLima, M.D.   |  |
| 22e. ADDRESS<br>14201 Laurel Park Drive, #100   |  |   |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |  |   |  |
| 23b. DATE<br>11/22/86   |  | 23c. NAME OF CEMETERY, NATALITY<br>Baltimore, Md.   |  | 23d. CITY OR TOWN<br>P.G.   |  | 23e. STATE<br>Md.   |  |
| 24. FUNERAL DIRECTOR NAME<br>Fleck Funeral Home, Inc.   |  |   |  | 25a. DATE<br>NOV 24 1986  |  |   |  |
| 25b. ADDRESS<br>7601 Sandy Spring Road  |  |   |  | 25c. REGISTRAR'S SIGNATURE<br>Lia Davidson-Randall  |  |   |  |

0250.2 000000



COLLON FIBER



NOV 24 1960

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return it to the funeral director. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 48, any injury, or other traumatic event, the medical examiner must be notified of the event.

024889 NOV 24 1986

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REG. NO. 86 30447   |  |
|---|--|--|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  |  |  |  |  |  | 2b. DATE OF DEATH   |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>HALLIE Comet SCHEIBE  |  |  |  |  |  |  |  |  |  | MONTH DAY YEAR<br>11-19-86  |  |
| 3. SEX male   |  |  |  |  |  |  |  |  |  | 2b. HOUR 800 A M  |  |
| 4. RACE Caucasian   |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>5-19-10  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS  |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR IF UNDER 24 HRS<br>MONTHS DAYS HOURS MIN.   |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland  |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel County MD.   |  |
| 7b. CITIZEN OF WHAT COUNTRY? United States  |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Police (Retired)                                       |  |
| 10. CITY OR TOWN OF DEATH Annapolis   |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Balto. City  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Anne Arundel General Hospital   |  |  |  |  |  |  |  |  |  | 12c. STREET ADDRESS / ZIP CODE<br>296 Mountain Ridge Apts./21061  |  |
| 13a. STATE Maryland   |  |  |  |  |  |  |  |  |  | 13b. COUNTY Anne Arundel  |  |
| 13c. CITY OR TOWN Glen Burnie   |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Charles Scheibe  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Tessie Landon   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO. 216-09-8617  |  |
| 17. INFORMANT ADDRESS<br>Phillip Scheibe 611 Bay Hills Dr. 21012 Arnold, MD   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 DAYS  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CGRGRN VASCULAR EMBOLUS WITH STROKE<br>(b) ATHEROSCLEROSIS<br>(c) DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10   |  |  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |  |  |   |  |
| 22a. I certify that (a) this hospital attended the deceased from 11/13, 19 86, to 11/19, 19 86, that (b) (we) lost saw the deceased alive on 11/18, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (c) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE DEGREE   |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED 11/19/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES A. SEAGER   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS 780 RITCHIE HWY SU PK MD   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  |  |  |  |  |  |  |  |  | 23b. DATE 11-21-86  |  |
| 23c. NAME OF CEMETERY OR CREMATORY Glen Haven   |  |  |  |  |  |  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Glen Burnie, A. A., MD   |  |
| 24. FUNERAL DIRECTOR NAME 495 RITCHIE HIGHWAY BARRANCO SEVERN PARK MD 21146   |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE NOV 20 1986  |  |

MEDICAL CERTIFICATION

05485 10012

10012

10012



023567 NOV 1986

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 0 4 4 8

|  |  |  |  |
|--|--|--|--|
| FOR STATE REGISTRAR  |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Dorsey Scholtz  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11 6 86  |  |
| 3. SEX<br>m  |  | 2b. HOUR<br>6:55 PM  |  |
| 4. RACE<br>Cauc.   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.   |  |
| 5. DATE OF BIRTH MONTH DAY YEAR<br>7 18 11   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7c. CITIZEN OF WHAT COUNTRY?<br>U.S.   |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ANNE ARUNDEL MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Annapolis   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>AACH                                       |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Mechanic  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Retired   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Md. 13b. COUNTY Anne Arundel 13c. CITY OR TOWN Severna Park   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>ECKHARDT EREGIUS SCHOLTZ  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ANNIE MAY O'MALLEY   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>220-12-2939  |  |
| 17. INFORMANT ADDRESS<br>Eckhardt Scholtz, Severna Park, MD  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiorespiratory arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) metastatic prostatic Cancer<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/4/86, 1986, to 11/6/86, 1986, that (I) (we) last saw the deceased alive on 11/6/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |
| 22b. SIGNATURE<br>Astrida Plucis   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22c. DATE SIGNED<br>11/6/86  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ASTRIDA PLUCIS  |  | 22e. ADDRESS<br>ANNAPOLIS, MARYLAND  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>CREMATION   |  | 23b. DATE<br>11/7/86   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Lee's  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>CLINTON Prince George MD.   |  |
| 24. FUNERAL DIRECTOR NAME<br>Bell Funeral Services, Prince Frederick   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 10 1986   |  |
| 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the medical examiner and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified at once.

*Alouatta palliata*

15. 10. 1943



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.DHMH - 16 50M 4/83  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 86 30449   |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>FRANCES LEE SHERMAN   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>November 13, 1986   |  |  |  | 2b. HOUR P<br>10:02 P  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Nov. 13, 1918  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel County, MD.                     |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>323 Old Riverside Road, |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife &         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Mother/Domes-   |  |
| 13a. STATE<br>Maryland   |  |   |  | 13b. COUNTY<br>A.A. Co.   |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Jacob Arthur Sours  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Florence May  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>213-16-1791   |  | 17. INFORMANT ADDRESS<br>Joyce A. Campbell Same as #13  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>dehydration</u>   |  |   |  |   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Severe COPD ASCVD</u>  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>Nov 10</u> , 19 <u>86</u> , to <u>Nov 14</u> , 19 <u>86</u> , that (1) (we) lost<br>saw the deceased alive on <u>Nov 10</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Sue Thompson MD</u>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br>11-14-86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Sue Thompson, M.D.  |  |   |  | 22e. ADDRESS<br>3918 Potee St., Balto., Md., 21225  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>11/17/86   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem Pk   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie, A.A. co. Md.              |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>McCully Funeral Homes  |  |   |  | 24b. ADDRESS<br>237 E. Patapsco Ave.,<br>Balto. Md. 21226   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 18 1986   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |

BP

250 100 100 100



00-23090

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 3 0 4 5 0  
EST

REG. NO.

|   |  |  |   |  |                            |   |  |  |  |
|---|--|--|---|--|----------------------------|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>GEORGE J SHOPF</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 02, 1986</b> |  | 2b. HOUR<br><b>1132 AM</b> |   |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>January 25, 1909</b>  |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY</b> MD                 |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |   |  |                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Beth Steel</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Pipe-fitter.</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  |  |   |  |                            | 13b. COUNTY<br><b>Anne Arundel</b>  |  | 13c. CITY OR TOWN<br><b>Pasadena</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>? unknown - unknown Shopf</b>  |  |  |   |  |                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>? unknown - ? unknown</b>         |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215-05-5266</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Carol Bowman / Pasadena, Md. 21122</b>   |                            |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>chronic lung disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b>              |  |  |   |  |                            |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |   |  |                            |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  |                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |                            |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>8667 FT. SMALLWOOD ROAD PASADENA, MD. 21122</b>  |                            |   |  |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>11/1</b> 19 <b>83</b> to <b>11/2</b> 19 <b>84</b> , that (1) (we) lost saw the deceased alive on <b>11/1/84</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did) (did not) view the body after death. |  |  |   |  |                            |   |  |  |  |
| 22b. SIGNATURE<br><b>Lorraine M. Dailey MD</b>  |  | DEGREE   |   | 22c. DATE SIGNED<br><b>11/3/86</b>   |                            |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LORRAINE M. DAILEY, M.D.</b>  |  | 22e. ADDRESS<br><b>8667 FT. SMALLWOOD ROAD PASADENA, MD. 21122</b>   |   |  |                            |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Nov. 5, 86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>   |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brooklyn, Anne Arundel, Md.</b>      |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>McCully Funeral Home / 3204 Mountain Rd. Pasadena, Md. 21122</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 5 1986</b>   |                            | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                           |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP

00-33028



KA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| FOR<br>1- STATE<br>REGISTRAR  |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.   |  |  |  |   |  |
|---|--|---|--|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Frances G. Slawson</b>   |  |   |  | 2a. DATE OF DEATH MONTH <b>10</b> DAY <b>31</b> YEAR <b>86</b>  |  |   |  | 2b. HOUR <b>1:15</b> P <b>M</b>  |  |  |  |   |  |
| 3. SEX <b>FEMALE</b>  |  | 4. RACE <b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH <b>8</b> DAY <b>24</b> YEAR <b>25</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS.                      |  | IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>  |  | IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b> |  |  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNE ARUNDEL GENERAL HOSPITAL</b> |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>REGISTERED NURSE</b>        |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. STATE <b>MARYLAND</b>  |  |   |  | 13b. COUNTY <b>ANNE ARUNDEL</b>   |  | 13c. CITY OR TOWN <b>RIVA</b>                                       |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  | 13e. STREET ADDRESS / ZIP CODE <b>2875 HAMBLETON ROAD 21140</b> |  |
| 14. FATHER'S NAME FIRST <b>RAYMOND</b> MIDDLE <b>GREEN</b> LAST <b></b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>MAY</b> MIDDLE <b>STEVENS</b> LAST <b></b>  |  |   |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  |   |  | 16b. SOCIAL SECURITY NO. <b>220-14-9189</b>   |  | 17. INFORMANT ADDRESS <b>DALLAS K, MULLINS SAME AS 13E</b>          |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Breast Cancer</b>   |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |   |  |  |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |   |  |   |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>  |  |   |  |   |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION <b></b>  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b></b>        |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <b></b>  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>H 83</b>   |  |   |  | 21f. LOCATION STREET <b>10/31</b> CITY OR TOWN <b>86</b> COUNTY <b></b> STATE <b></b>        |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/31</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>Stuart E. Selouch, M.D.</b>   |  |   |  | DEGREE <b></b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED <b>10/31/86</b>   |  |  |  |   |  |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stuart E. Selouch, M.D.</b>  |  |   |  | 23b. ADDRESS <b>57 Franklin St Annapolis, md 21401</b>  |  |   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  |   |  | 23b. DATE <b>11-3-86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>LAKEMONT CEMETERY</b>         |  | 23d. LOCATION CITY OR TOWN <b>DAVIDSONVILLE</b> COUNTY <b>A.A.CO.</b> STATE <b>Md.</b>       |  |  |  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>ROBERT E. EVANS</b> ADDRESS <b>1212 WEST ST. ANNAPOLIS</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1986</b>                    |  | 25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>                                      |  |  |  |   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8630452

REG. NO.

|   |  |  |  |   |  |  |   |  |  |
|---|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Agnes L. Smith</i>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>NOV. 1, 1986                       |   |  | 2b. HOUR<br>6:00 P.M.  |   |  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>NOV. 21, 1900   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ANNE ARUNDEL COUNTY MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>HARWOOD BRASHEARS  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NURSING CARE 4201 SANDS RD. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>MARYLAND  |  |  |  | 13b. COUNTY<br>ANNE ARUNDEL   |  | 13c. CITY OR TOWN<br>LOTHIAN   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>BENJAMIN LANHAM   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>MIDDLE LAST<br>UNKNOWN  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN)<br>NO  |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-36-8508  |  | 17. INFORMANT ADDRESS<br>JOSEPH W. LANHAM SAME AS 13E  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiorespiratory arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Atherosclerotic coronary vascular disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Organic brain syndrome</i> |  |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>5 minutes</i><br><i>3 years</i>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (1) this hospital attended the deceased from _____, 19_____, to _____, 19_____, that (1) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.         |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><i>Gregory S. Neill</i>   |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>11/4/86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Gregory S. Neill   |  |  |  |   |  | 22e. ADDRESS<br>134 Owensville Rd West River MD 20778  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL   |  |  | 23b. DATE<br>11-4-86   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>ST. MARYS CEMETERY |  | 23d. LOCATION<br>ANNAPOLIS A.A. CO. MD. |  |  |
| 24. FUNERAL DIRECTOR<br>ROBERT E. EVANS 1212 WEST ST. ANNAPOLIS, MD   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 19 1986   |   |  |  |
|   |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of your findings.

BP



06  
Q34

RECEIVED

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 60M 7/84  
(VRA 15, 4)


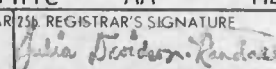
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 0 4 5 3

1. FOR  
STATE  
REGISTRAR

REG. NO.

EST

|   |  |   |   |   |   |  |  |  |   |  |
|---|--|---|---|---|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARCELLE B SMITH</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 02, 1986</b>          |   |   | 2b. HOUR<br><b>2.24 AM</b>   |  |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 11, 1921</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b>   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY</b> MD.               |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF IN A FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>   |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |   |   |   | 13b. COUNTY<br><b>AA</b>  |  | 13c. CITY OR TOWN<br><b>Glen Burnie</b>                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Leon Bryant</b>  |  |   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Carrie Arnold</b> |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>220-09-3462</b>                        |   | 17. INFORMANT ADDRESS<br><b>Frank L. Smith, Same as 13</b>            |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOVASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Bronchial Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Hemorrhage</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)  |  |   |   |   |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>     |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)        |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) see the body after death.   |  |   |   |   |   |  |  |  |   |  |
| 22b. SIGNATURE<br>   |  |   |   |   |   | DEGREE<br><b>PHYSICIAN</b>   |  | 22c. DATE SIGNED<br><b>11/02/86</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. STEPHEN IZZZI</b>   |  |   |   |   |   | 22e. ADDRESS<br><b>7010 RITCHIE HIGHWAY<br/>GLEN BURNIE MARYLAND 21061</b>           |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>Nov. 5, 1986</b>                                      |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Park</b>     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie AA MD</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>James S. Kirkley, Glen Burnie, MD</b>  |  |   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 3 - 1986</b>                                 |  | 25b. REGISTRAR'S SIGNATURE<br>        |   |  |

MEDICAL CERTIFICATION

BP

251-ES-0

1

026209 DEC -5 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 0 4 5 4

REG. NO.

|   |  |  |  |   |  |  |   |  |  |
|---|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Virginia A. Smith  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov. 30, 1986                   |   |  | 2b. HOUR<br>M  |   |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Caucasion   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 26, 1914   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Mississippi  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel Co. MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Crownsville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Farfield Nursing Center |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>homemaker  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>home  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>A.A. Co.  |  | 13c. CITY OR TOWN<br>Severna pk   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 13e. STREET ADDRESS / ZIP CODE<br>452 Yorkshire Dr. 21146  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>O.C. Addison  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Cora Addison   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-----   |  | 17. INFORMANT<br>Harley Smith   |  | ADDRESS<br>Same as Above   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic C.V.D.</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:<br><u>Cerebrovascular Accident</u>   |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>OCT 19 86</u> to <u>Nov 19 86</u> , that (I) (we) last saw the deceased alive on <u>27 Nov 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><u>William P. Jones</u>   |  |  | DEGREE<br>MD   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><u>2 Dec 86</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>William P. Jones, MD</u>  |  |  | 22e. ADDRESS<br><u>695 America Ct. 21035</u>                           |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  | 23b. DATE<br>12-6-86   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>MAGNOLIA CEM                             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Mcbile, Alabama |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>BRANKO FH. 501 RITCHIE HWY SEVERNA PK MD 21146</u>   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 4 1986                                    |  | 25b. REGISTRAR'S SIGNATURE<br><u>Anita Davidson-Randall</u>   |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top of the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 0 4 5 5

025025 NO 25 86

|  |  |  |  |
|--|--|--|--|
| FOR<br>1. STATE<br>REGISTRAR   |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Naomi Snyder</b>  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11 20 86</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 2b. HOUR<br><b>3:05 PM</b>   |  |
| 4. RACE<br><b>Caucasian</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.  |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 05 1899</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne-Arundel Co.</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Brooklyn Park</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Meridian Nursing Center</b>          |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>A-A. Co.</b>   |  |
| 13c. CITY OR TOWN<br><b>Linthicum</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 13e. STREET ADDRESS / ZIP CODE<br><b>6219 Groveland Road, 21090</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Livingston</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Daisy Thompson</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-20-9478</b>   |  |
| 17. INFORMANT<br><b>William F. Lins, Jr.,</b>  |  | ADDRESS<br><b>6219 Groveland Road</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Retrospective Coronary Artery Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>diabetes, cerebrovascular retinal disease</b>   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>Dr. Schwartz</b>  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22c. DATE SIGNED<br><b>11/22/86</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Schwartz</b>   |  | 22e. ADDRESS<br><b>606 Hammonds Lane</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/24/86</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Park</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie A.A. Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 24 1986</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Julia Gordon-Rodgers</b>  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



APR 25 1944  
RECEIVED  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.  
OFFICE OF THE ASSISTANT SECRETARY  
FOR AGRICULTURAL MARKETING  
DIVISION OF MARKET ECONOMICS

TO: DIRECTOR, BUREAU OF AGRICULTURAL MARKETING  
FROM: ASSISTANT SECRETARY FOR AGRICULTURAL MARKETING  
SUBJECT: [Illegible]

[Illegible text block]



024263

NOV 19 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and place them in the container provided for the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the funeral director must be notified at once.

FOR  
STATE  
1- REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 0 4 5 6

REG. NO.

|  |  |  |   |   |   |   |  |
|--|--|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Ann Constance Sondergaard   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 - 12 - 86 |   |   | 2b. HOUR<br>7:45pm  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasian   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 - 20 - 17   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel County MD.                                 |  |
| 10. CITY OR TOWN OF DEATH<br>Severna Park  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Meridian Nursing Center |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Manager                     |  |
|  |  |  |   |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Catalog Sales  |  |
| 13a. STATE<br>New York   |  | 13b. COUNTY<br>---   |   | 13c. CITY OR TOWN<br>Schenectady  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Lougie Farnace   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Concetta D'Ascenzio   |   | 13e. STREET ADDRESS / ZIP CODE<br>----- 99999   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>067-09-7698   |   | 17. INFORMANT<br>ADDRESS<br>Neal Sondergaard 591 Treslow Glen Drive<br>Severna Park, MD 21146   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Coronary artery disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |  |   |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/7</u> , 19 <u>86</u> , to <u>11/12</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>11/10</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                |  |  |   |   |   |   |  |
| 22b. SIGNATURE<br><u>M. Mullins, MD</u>  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br><u>11/13/86</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Margaret Mullins, MD  |  |  |   | 22e. ADDRESS<br>Cape St. Claire Shopping Center, Annapolis, MD  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>11-14-86  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Hillcrest Cemetery  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Annapolis A.A. Md.                                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>BARRANCO FUNERAL HOME  |  |  |   | 495 RITKIE HWY SEVERNA PARK, MD   |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 14 1986  |  |
|  |  |  |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>                                     |  |

034362 021002

034362 021002

03

034362 021002

25565 DEC-2

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 30457

REG. NO.

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARtha E. Stegney</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-26-86</b>  |   | 2b. HOUR<br><b>10:00 AM</b>   |
| 3. SEX<br><b>F</b>  | 4. RACE<br><b>B</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 17 51</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>35</b>                                  | IF UNDER 1 YEAR<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>USA</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Annapolis</b> MD.                                    |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Anne Arundel Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. STATE<br><b>MARYLAND</b>   | 13b. COUNTY<br><b>A.A.</b>  | 13c. CITY OR TOWN<br><b>ANNAPOLIS</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>2044 Parker Drive 21401</b>                                  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIAM HEBRON</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>RACHEL CROMWELL</b>   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>212-54-8944</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Annopolis, Md. 21401</b><br><b>LEWIS STEGNEY 2044 Parker Drive</b> |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>(a) Negative failure</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>(b) Renal failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a<br><b>Recent DVT, Gastrointestinal hemorrhage, IDDM, Septicemia</b>  |   |   |   |   |   |
| 19a. DATE OF OPERATION<br><b>none</b>   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>none</b>   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/14</b> , 19 <b>86</b> , to <b>11/26</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>11/26/86</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.          |   |   |   |   |   |
| 22b. SIGNATURE<br><b>Eric A. Phillips</b>   |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>11/26/86</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ERIC A. PHILLIPS</b>  |   | 22e. ADDRESS<br><b>1885 Bond Drive, Annapolis, Md.</b>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   | 23b. DATE<br><b>12-1-1986</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HILL CREST CEMETERY</b>  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Annapolis A.A. Maryland</b>                    |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>  |   | ADDRESS<br><b>Annapolis, Md. 21401</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 01 1986</b>   |   |
|   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Anderson-Kandath</b>   |   |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the funeral director. Page 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



024755 NOV 21

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: When this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove sections 1 and 2 and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  | REG. NO.   |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>A.K.A. <u>Frederick</u><br><u>FRED</u> <u>William</u> <u>STORTON</u>  |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><u>11</u> <u>16</u> <u>86</u>  |  |  |  | 2b. HOUR<br><u>12<sup>25</sup></u> <u>A</u> <u>M</u>   |  |
| 3. SEX<br><u>Male</u>   |  | 4. RACE<br><u>White</u>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><u>05</u> <u>14</u> <u>05</u>  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><u>81</u> YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>England</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Anne Arundel County</u> <u>MD.</u>  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Annapolis</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Anne Arundel General Hosp</u> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Owner-Operator</u>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Barber Shop</u>                              |  |  |  |
| 13a. STATE<br><u>MD</u>   |  | 13b. COUNTY<br><u>AA</u>  |  | 13c. CITY OR TOWN<br><u>Annapolis</u>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><u>1008 Jackson Street</u> <u>21401</u>            |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><u>Fred</u> <u>Storton</u>   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><u>Unknown</u>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>Yes</u>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><u>661-344329</u>  |  | 17. INFORMANT<br><u>Mary Elizabeth Storton</u>  |  |  |  | ADDRESS<br><u>Same as</u>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Shock</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Acute Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><u>Metastatic Gastric Carcinoma</u>   |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <u>19</u>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <u>11-15</u> , 19 <u>86</u> , to <u>11-16</u> , 19 <u>86</u> , that (1) (we) last saw the deceased alive on <u>11-16</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>N. Capozzoli</u>   |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>11-16-86</u>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Nicholas Capozzoli MD</u>   |  |   |  |   |  | 22e. ADDRESS<br><u>25 Shaw Street, Annapolis, MD</u>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>   |  |   |  | 23b. DATE<br><u>Nov. 18, 1986</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Hillcrest</u>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Annapolis AA MD</u>                 |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Taylor Funeral Chapel - Annapolis MD</u>   |  |   |  |   |  | ADDRESS<br><u>25 Shaw Street, Annapolis MD</u>   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>NOV 20 1986</u>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Lin E. ...</u>  |  |



0223570 NOV 12 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 4 should be detached for use as the burial/transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. **IMPORTANT:** If item 21 is marked as item 21 shows any injury, or other trauma, the medical examiner must be notified at once.

|   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REG. NO. 86 30459   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Robert Austin Summers  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>November 5, 1986  |  |  |  |  |   |  |  |  |  | 2b. HOUR<br>1728 M  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>Male  |  |  |  |  | 4. RACE<br>White   |  |  |  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>July 10, 1917  |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS.  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel Co. MD.                                    |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Ft. Meade  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Kimbrough Army Community Hosp. |  |  |  |  |   |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Stockman                       |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Store Read's Drug                        |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  |  |  |  | 13b. COUNTY<br>A A co.   |  |  |  |  | 13c. CITY OR TOWN<br>Glen Burnie  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  | 13e. STREET ADDRESS / ZIP CODE<br>905 Phyllen Court 21061                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Austin Summers   |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Edna Long  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>Korea/Viet 224-07-3608   |  |  |  |  | 17. INFORMANT (Wife) ADDRESS<br>Mrs. Dora E. Summers Same as #13  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| MEDICAL CERTIFICATION   |  |  |  |  |  |  |  |  |  | 18. CAUSE OF DEATH (Enter only one name per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiorespiratory Failure<br>DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Pulmonary Disease years<br>DUE TO, OR AS A CONSEQUENCE OF (c) Congestive Heart Failure and Myocardial Infarction 7 days |  |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 hours                       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>Bronchitis, Possible Pulmonary Embolism   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/27, 19 86, to 11/5, 19 86, that (I) (we) last saw the deceased alive on 11/5, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  | 22b. SIGNATURE DEGREE<br>Mike A. Royal M.D. M.C.P.M. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |  |  |  |   |  |  |  |  | 22c. DATE SIGNED<br>11/5/86   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MIKE A. ROYAL M.D. M.C.P.M.  |  |  |  |  | 22e. ADDRESS<br>MEDICAL CLINIC, FT MEADE   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  |  |  | 23b. DATE<br>Nov 12, 1986  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington Nat'l Cem.  |  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Ft. Myers Va.  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Singleton Funeral Home   |  |  |  |  |  |  |  |  |  | 24b. ADDRESS<br>Glen Burnie, Maryland   |  |  |  |  |   |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 10 1986                                  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>A. J. Gordon-Randall |  |  |  |  |  |  |  |  |  |



PCP02 88

052850 1010

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*



023551 NOV

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PLACE OF THE WORD "DECEASED". GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, WITH FORM #1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

86 30460  
REG. NO.

|  |         |   |  |  |        |   |                                 |   |                       |   |     |                            |          |  |          |
|--|---------|---|--|--|--------|---|---------------------------------|---|-----------------------|---|-----|----------------------------|----------|--|----------|
| 1. FOR STATE REGISTRAR   |         | DECEASED NAME (TYPE OR PRINT)   |  | FIRST  | MIDDLE | LAST  | 2a. DATE OF DEATH               |   | DATE KNOWN ESTI-MATED | MONTH                                   | DAY | YEAR                       | 2b. HOUR |  |          |
|  |         | ROBERT O. SWIFT   |  |  |        |   | 11 3 1986                       |   |                       |   |     |                            |          |  |          |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  |  | MONTH  | DAY    | YEAR  | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. MONTHS   | IF UNDER 24 HRS. DAYS | 7c. DATE PRONOUNCED DEAD                |     | MONTH                      | DAY      | YEAR   | 2d. HOUR |
| Male   | White   | 8-30-1986   |  |  |        |   | YRS. 2                          | 7   |                       | 11 3 1986                               |     |                            |          |  |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |        | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                 |   |                       |   |     |                            |          |  |          |
| Maryland   |         | U.S.A.  |  | Anne Arundel Co. MD.   |        |   |                                 |   |                       |   |     |                            |          |  |          |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |        | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                                 |   |                       |   |     |                            |          |  |          |
| Glen Burnie  |         | North Arundel Hospital  |  | -----  |        | -----   |                                 |   |                       |   |     |                            |          |  |          |
| 13a. STATE   |         | 13b. CITY OR TOWN   |  | 13c. INSIDE CITY LIMITS?   |        | 13e. STREET ADDRESS   |                                 |   |                       |   |     |                            |          |  |          |
| MD   |         | A.A.  |  | Glen Burnie  |        | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                 | 7717 Leigh Rd. (21061)  |                       |   |     |                            |          |  |          |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |        | 16b. SOCIAL SECURITY NO.  |                                 | 17. INFORMANT   |                       | ADDRESS                                 |     |                            |          |  |          |
| William O. Swift   |         | Kimberly A. Marine  |  | No   |        | -----   |                                 | Kimberly Swift  |                       | (Same as 13e)                           |     |                            |          |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |   |  |  |        |   |                                 |   |                       |   |     |                            |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |
| PART I DEATH WAS CAUSED BY:  |         |   |  |  |        |   |                                 |   |                       |   |     |                            |          |  |          |
| IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u>   |         |   |  |  |        |   |                                 |   |                       |   |     |                            |          | MINUTES                                      |          |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |  |  |        |   |                                 |   |                       |   |     |                            |          |  |          |
| (b) <u>RESPIRATORY FAILURE</u>   |         |   |  |  |        |   |                                 |   |                       |   |     |                            |          | HOURS  |          |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |  |  |        |   |                                 |   |                       |   |     |                            |          |  |          |
| (c) <u>CONGENITAL HEART DISEASE - SINGLE VENTRICLE</u>   |         |   |  |  |        |   |                                 |   |                       |   |     |                            |          | VENTRICLE                                    |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |         |   |  |  |        |   |                                 |   |                       |   |     |                            |          |  |          |
| 19a. DATE OF OPERATION   |         |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |        |   |                                 | 20. AUTOPSY?  |                       |   |     |                            |          |  |          |
|  |         |   |  |  |        |   |                                 | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |                       |   |     |                            |          |  |          |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |        |   |                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                       |   |     |                            |          |  |          |
|  |         |   |  |  |        |   |                                 |   |                       |   |     |                            |          |  |          |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |         |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |        |   |                                 | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |                       |   |     |                            |          |  |          |
|  |         |   |  |  |        |   |                                 |   |                       |   |     |                            |          |  |          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . |         |   |  |  |        |   |                                 |   |                       |   |     |                            |          |  |          |
| ACTUAL SIGNATURE <u>Charles A. Seaker</u>  |         |   |  | TITLE (SPECIFY) M.D. <u>DEPUTY</u>   |        |   |                                 | MEDICAL EXAMINER  |                       |   |     | DATE SIGNED <u>11/6/86</u> |          |  |          |
| EXAMINER'S NAME (TYPE OR PRINT) <u>CHARLES A. SEAKER</u>   |         |   |  | ADDRESS <u>780 RITCHIE HWY, SU. PK.</u>  |        |   |                                 |   |                       |   |     |                            |          |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |   |  | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY                                  |                                 |   |                       | 23d. LOCATION CITY OR TOWN COUNTY STATE |     |                            |          |  |          |
| Cremation  |         |   |  | 11/7/'86   |        | Westview Mem. Pk.   |                                 |   |                       | Catonsville, Balto., MD                 |     |                            |          |  |          |
| 24. FUNERAL DIRECTOR NAME  |         |   |  |  |        |   |                                 | 25a. DATE REC'D. BY REGISTRAR   |                       | 25b. REGISTRAR'S SIGNATURE              |     |                            |          |  |          |
| George J. Gonce, 4001 Ritchie Hwy., Baltimore, MD (21225)  |         |   |  |  |        |   |                                 | NOV - 7 1986  |                       | <u>Julia Davidson-Paulson</u>           |     |                            |          |  |          |

039521 MAY 10 69

025294 NOV 25 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 30461

REG. NO.

EST

|   |   |   |   |  |   |
|---|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>LEIGH - (NMN) TALLMAN  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 21, 1986  |  | 2b. HOUR<br>515 AM                                |
| 3. SEX<br>Male  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 11, 1920  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.  |  | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.         |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ANNE ARUNDEL COUNTY MD.                                 |  |   |
| 10. CITY OR TOWN OF DEATH<br>GLEN BURNIE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NORTH ARUNDEL HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Lab. Worker                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Westinghouse |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   |   |   |  |   |
| 13a. STATE<br>Maryland  | 13b. COUNTY<br>A A Co.  | 13c. CITY OR TOWN<br>Severn   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>1247 Thompson Ave. 21144                           |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Cecil Tallman   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Clara (Unknown)  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII 134.05.1266   |   | 17. INFORMANT (Wife) ADDRESS<br>Mrs. Margaret Tallman Same As #13                    |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Septic shock</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>pneumonia, right lower</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>alcoholism</u>  |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |   |   |   |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |   |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 22a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 22b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 22c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22d. I certify that (I) (the undersigned) attended the deceased from <u>NOV. 20</u> 19 <u>86</u> to <u>NOV. 21</u> 19 <u>86</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>NOV. 21</u> 19 <u>86</u> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> view the body after death. |   |   |   |  |   |
| 23a. SIGNATURE<br><u>Dr. Hsueh Hung, M.D.</u>   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 23b. DATE SIGNED<br><u>Nov. 21. 86</u>   |   |
| 23c. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DO HSUEH HUNG, M.D.  |   | 23d. ADDRESS<br>3450 FT. MEADE ROAD, ROOM 207<br>LAUREL, MARYLAND 20707   |   |  |   |
| 24a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |   | 24b. DATE<br>Nov 24, 1986   |   | 24c. NAME OF CEMETERY OR CREMATORY<br>Maryland Vet. Cemetery                         |   |
| 24d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Crownsville A A Co. Md.   |   |   |   |  |   |
| 25. FUNERAL DIRECTOR<br>(NAME)<br>Singleton Funeral Home  |   | 25b. ADDRESS<br>Glen Burnie, Maryland   |   | 25c. DATE REC'D. BY REGISTRAR<br>NOV 25 1986   |   |
| 25d. REGISTRAR'S SIGNATURE<br><u>Division Registrar</u>   |   |   |   |  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use on the burial-transit permit. Then please remove carbon copies of this certificate and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, it should be reported to the State Dept. of Health and Mental Hygiene.

BP

18402 30461

88

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

18402

30461



*[Faint, illegible handwriting]*

*[Faint, illegible handwriting]*

X

*[Faint, illegible handwriting]*

*[Faint, illegible handwriting]*

NOV 25 1880

025173 NOV 25 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 30462

REG. NO.

|  |  |  |  |   |   |   |  |  |
|--|--|--|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>DOROTHEA Dentry THEISZ   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 20, 1986 |   |   | 2b. HOUR<br>6 A M   |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>September 24, 1912  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS                                     |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel MD.                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>Linthicum   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>826 Main Ave. |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |  |  |
|  |  |  |  |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home                                 |  |  |
| 13a. STATE<br>Maryland   |  |  |  | 13b. COUNTY<br>Anne Arundel   |   | 13c. CITY OR TOWN<br>Linthicum  |  |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  | 13e. STREET ADDRESS / ZIP CODE<br>826 Main Ave. 21090   |   |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles A. Cross   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Minnie Dentry  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A  |   | 17. INFORMANT (Daughter) ADDRESS<br>Mrs. Eleanor V. Breeden Arnold, Md. 21012 |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic Colon Cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |  |  |   |   |   |  |  |
| MEDICAL CERTIFICATION  |  |  |  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on <u>11/20</u> , 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |   |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br>11/20/86  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Yeong Oh  |  |  |  | 22e. ADDRESS<br>1412 Crain Highway Glen Burnie, Md. 21061   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>November 22 1986  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Bluff Cemetery  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Annapolis Anne Arundel Md.      |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Singleton Funeral Home, Glen Burnie, Maryland  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 25 1986  |   |   |  |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked as item 18 show any injury, or other traumatic event, the medical examiner will be notified at once.

052133 11/22/22

RECEIVED

052133

052133

052133



025004 NOV 26

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 30463

REG. NO.

EDT

|  |   |   |   |   |   |
|--|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>DELIA M THOMPSON  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 19, 1986                      |   | 2b. HOUR<br>7 30 AM                       |
| 3. SEX<br>Female   | 4. RACE<br>Caucasian  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>November 20, 1897   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ANNE ARUNDEL COUNTY MD.                             |   |
| 10. CITY OR TOWN OF DEATH<br>GLEN BURNIE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NORTH ARUNDEL HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home   |   |
| 13a. STATE<br>Maryland   |   |   | 13b. COUNTY<br>P.G.   | 13c. CITY OR TOWN<br>Hyattsville  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George W. Esher  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Amanda Mangle                |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |   | 16b. SOCIAL SECURITY NO.<br>195-16-9951   |   | 17. INFORMANT<br>(Executor) 104 Cromwell Avenue<br>Leonard E. Eagley Glen Burnie, Md. 21061 |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>GASTROINTESTINAL BLEED</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |   |   |   |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                   |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |   |   |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)              |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT 19 86</u> to <u>NOV 19 86</u> that (I/we) lost<br>saw the deceased alive on <u>11/18 86</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated<br>above. (If not, (I/We) did not view the body after death.)  |   |   |   |   |   |
| 22b. SIGNATURE<br><u>[Signature]</u>   |   | DEGREE<br>70 ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>     |   | 22c. DATE SIGNED<br>NOV 19 1986   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>TOM SHIVERS M.D.  |   | 22e. ADDRESS<br>518 SOUTH CAMP MEADE ROAD<br>LINTHICUM MARYLAND 21090   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |   | 23b. DATE<br>11/23/86   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Odd Fellows Cemetery                                  |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Shamokin Northumberland Pa.  |   | 23e. DATE REC'D. BY REGISTRAR<br>NOV 24 1986  |   |   |   |
| 23f. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |   |   |   |   |   |

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3045

00

UNITED STATES  
DEPARTMENT OF AGRICULTURE  
WASHINGTON, D. C.

OFFICE OF THE  
SECRETARY OF AGRICULTURE

025001 100250

*[Faint, mostly illegible handwritten text, possibly a letter or report.]*

CARDIO-PHYSIOLOGICAL  
LABORATORY

*[Faint, mostly illegible handwritten text, possibly a letter or report.]*

*[Faint, mostly illegible handwritten text, possibly a letter or report.]*

24647 NOV 20 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

30464

REG. NO.

EST

|  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CECELIA PATRICIA TOLOCZKO</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 14, 1986</b> |   |  | 2b. HOUR<br><b>1105 AM</b>  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>February 2, 1923</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Massachusetts</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY</b> MD.                          |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |   |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Anne Arundel</b>   |  | 13c. CITY OR TOWN<br><b>Glen Burnie</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>605 Baylor Rd. 21061</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Michael (Michael) Coyne</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Martha Howe</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>024 18 3469</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Cecelia S Ostrowski 454 College Pkwy. Arnold, MD 21012</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Shock.</b>  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 hrs.</b>  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute inferior myocardial infarction</b>  |  |  |  |   |  |   |  | 36 hours   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Hypertension</b>  |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Cerebrovascular disease</b>  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>11/14</b> 19 <b>86</b> to <b>11/14</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>11/14</b> 19 <b>86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Gerard Church M.D.</b>  |  |  |  | DEGREE  |  |   |  | 22c. DATE SIGNED<br><b>11/14/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GERARD CHURCH, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>8 EVERGREEN RD SEVERNA PARK, MARYLAND 21146</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Nov. 17, '86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie, Anne Arundel MD</b>               |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>McCully Funeral Homes</b>   |  |  |  | 3204 Mountain Rd.<br>Pasadena, MD 21122   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 18 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |

MEDICAL CERTIFICATION

9  
9

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

4-2-90

000000000000

*[Faint, mostly illegible handwritten text and markings across the page, possibly a ledger or notebook entry.]*

1

0-23138

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 30465

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |                         |  |  |   |   |
|---|-------------------------|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Audrey A. Tull</b>                               |                         |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 1, 1986</b>   |   | 2b. HOUR<br>A.M.<br><b>1:00</b>                                   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 24, 1917</b> |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                            |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                 |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 10. CITY OR TOWN OF DEATH<br><b>Glen Burnie</b>   |                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>903 Andrews Avenue</b> |   |   |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retail Clerk</b> |                         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>  |   |   |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel</b> MD.                         |                         |  |  |   |   |
| 13a. STATE<br><b>MD</b>   |                         | 13b. COUNTY<br><b>AA</b>                                   | 13c. CITY OR TOWN<br><b>Glen Burnie</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 13e. STREET ADDRESS / ZIP CODE<br><b>903 Andrews Avenue 21061</b> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Whitney</b>                           |                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ella Sweat</b>   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>       |                         | 16b. SOCIAL SECURITY NO.<br><b>213-14-9807</b>             |  | 17. INFORMANT<br>ADDRESS<br><b>Kenneth M. Tull, Sr., same as 13</b>   |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*respiratory arrest*

DUE TO, OR AS A CONSEQUENCE OF

(b)

*lung cancer*

DUE TO, OR AS A CONSEQUENCE OF

(c)

*smoking*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

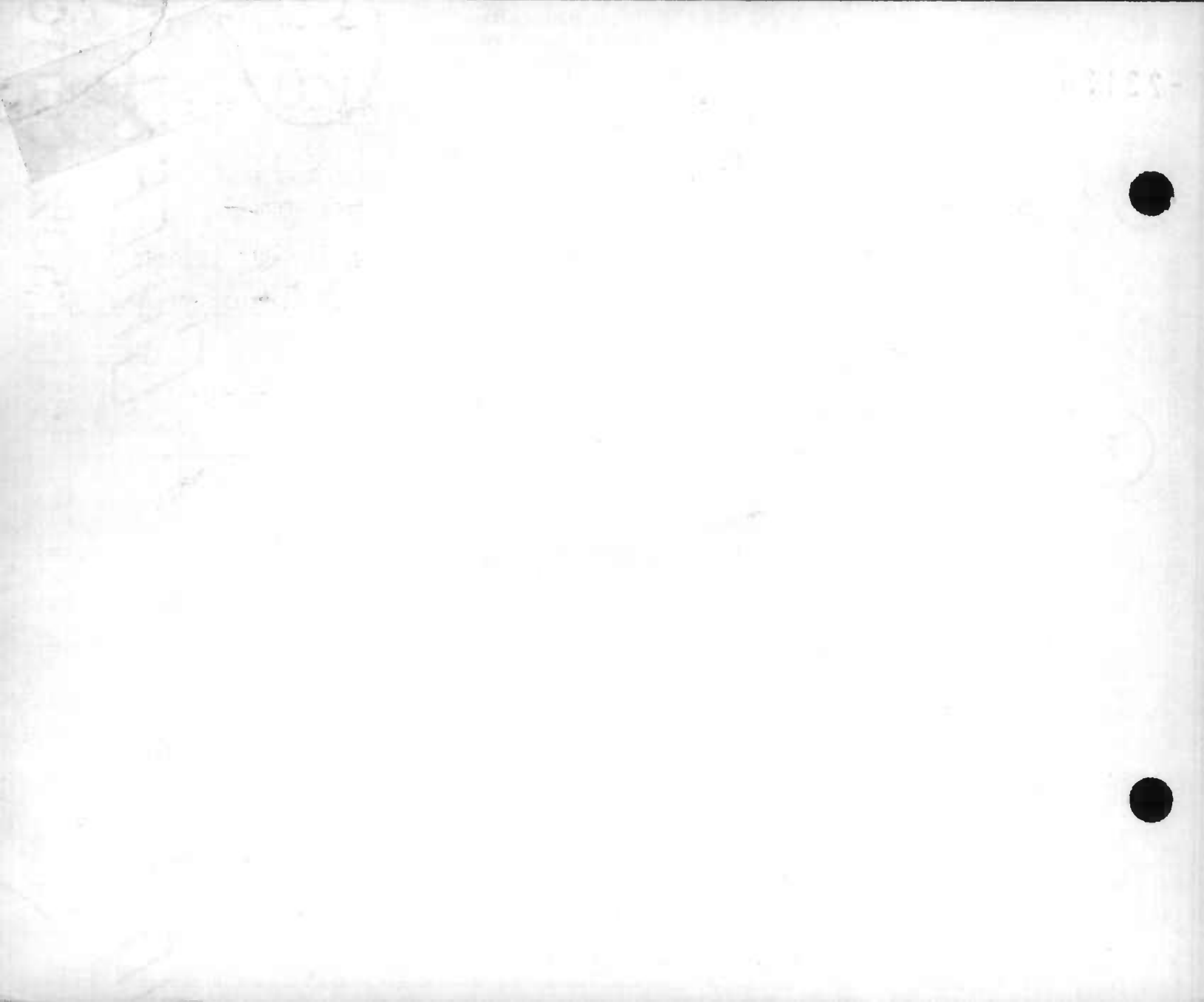
|   |  |  |  |   |   |
|---|--|--|--|---|---|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>7/1</u> , 19 <u>85</u> , to <u>11/1</u> , 19 <u>86</u> , that (1) (we) last saw the deceased alive on <u>about 10/1</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |  |  |   |   |
| 22b. SIGNATURE<br><i>James J. Benjamin</i>  |  | DEGREE<br><i>MD</i>  |  | 22c. DATE SIGNED<br><u>11/3/86</u>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. James J. Benjamin, M.D.</b>   |  | 22e. ADDRESS<br><b>653 Old Mill Road, Millersville, MD</b>             |  |   |   |

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br><b>Burial</b>      | 23b. DATE<br><b>Nov. 3, 1986</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Park</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie AA MD</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>James S. Kirkley, Glen Burnie, MD</b> |                                  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 3 - 1986</b>              | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>             |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, show any injury, or other traumatic event, the medical examiner must be notified of once.



026398 DEC -9 86

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

30468

REG. NO.

EST

|  |  |   |   |  |  |   |
|--|--|---|---|--|--|---|
| 1. DECEASED NAME <b>aka</b> FIRST <b>Frances</b> MIDDLE <b>Lorraine</b> LAST <b>Vollmerhausen</b><br>(TYPE OR PRINT) <b>FRANCIS LORRAINE VOLLMERHAUSEN</b>   |  |   | DATE OF DEATH MONTH <b>NOVEMBER</b> DAY <b>30</b> YEAR <b>1986</b> 2b HOUR <b>514 PM</b>        |  |  |   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>21</b> YEAR <b>22</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                                   | IF UNDER 24 HRS<br>HOURS <b></b> MIN. <b></b> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>               |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home Maker</b>                           |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>A.A.</b> 13c. CITY OR TOWN <b>Glen Burnie</b>   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>203 Kuethe Road 21061</b>                   |   |
| 14. FATHER'S NAME<br>FIRST <b>Richard</b> MIDDLE <b>P.</b> LAST <b>Vosler</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Ethel</b> MIDDLE <b>S.</b> LAST <b>Byrd</b>  |   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217-20-9961</b>  |   | 17. INFORMANT<br><b>Joan Marie Bettius</b> ADDRESS <b>Same as 13e</b>                |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>Lymphoma of lungs</b><br>(c) <b>massive Pulm. Embolism</b>   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1/2 hour</b><br><b>1 year</b> |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I<br><b>Pulm.</b>  |  |   |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)        |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>10/30</b> 19 <b>86</b> to <b>11/30</b> 19 <b>86</b> , that (1) (we) last saw the deceased alive on <b>11/30</b> 19 <b>86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death. |  |   |   |  |  |   |
| 22b. SIGNATURE<br><b>DAVID A. SCHWARTZ, MD</b>   |  |   |   | 22c. DATE SIGNED<br><b>12/1/86</b>   |  |   |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DAVID A. SCHWARTZ, MD</b>  |  |   |   | 22f. ADDRESS<br><b>7845 OAKWOOD ROAD GLEN BURNIE, MD 21061</b>                       |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>12/4/86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>                         |  |   |
| 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>A.A.</b> STATE <b>Md</b>  |  | 23e. DATE REC'D. BY REGISTRAR<br><b>DEC 5 1986</b>  |   |  |  |   |
| 24. FUNERAL DIRECTOR<br><b>George J. Gonce 4001 Ritchie Hwy Balto Md</b>   |  |   |   |  |  |   |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



88-3048

100-3048

Department of Justice  
Federal Bureau of Investigation  
Washington, D. C.  
20535  
Date: 10-10-68  
To: [illegible]  
From: [illegible]  
Subject: [illegible]  
Re: [illegible]  
Enclosure: [illegible]  
100-3048-100

[Faint, mostly illegible text and markings, possibly a signature or stamp area]



13403 38

05211 12250



RECEIVED  
JAN 11 1950

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

86 30468

|  |                    |  |   |   |  |   |
|--|--------------------|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Charles William Wagner</b>  |                    |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11 21 1986</b> |   |  | 2b. HOUR <b>M</b>   |
| 3. SEX <b>M</b>  | 4. RACE <b>Can</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>1 5 21</b>   | 6. AGE (IN YEARS)<br>LAST MONTH DAY YRS. <b>65</b>  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>11 21 1986</b>                           | 7d. HOUR <b>1737</b>  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                    | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>AA</b>                                      |   |
| 10. CITY OR TOWN OF DEATH<br><b>Glen Burnie</b>  |                    | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>North Arundel</b> |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Elect. Foreman</b> |   |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beth Steel</b>   |                    | 13a. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |   | 13b. STREET ADDRESS<br><b>156 Park Road 21122</b>   |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles W. Wagner</b>   |                    | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lillian M. Smith</b>   |   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes WW II</b>  |                    | 16b. SOCIAL SECURITY NO.<br><b>218-10-8195</b>   |   | 17. INFORMANT<br><b>Pasadena, Md 21122</b><br><b>Charles W. Wagner 218 Drum Ave N.</b>  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>A.S.C.V.D.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |                    |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                    |  |   |   |  |   |
| 19a. DATE OF OPERATION   |                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                    | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                    |  |   |   |  |   |
| ACTUAL SIGNATURE <b>William P. Jones</b>   |                    | TITLE (SPECIFY)<br><b>Deputy</b>   |   | MEDICAL EXAMINER  |  | DATE SIGNED <b>11/22/86</b>   |
| EXAMINER'S NAME (TYPE OR PRINT) <b>William P. Jones, M.D.</b>  |                    | ADDRESS <b>695 America Crt. Davidsonville, Md. 21035</b>   |   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                    | 23b. DATE<br><b>11/25/86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore === Md</b>               |
| 24. FUNERAL DIRECTOR<br><b>George J. Gonce 4001 Ritchie Hgwy Balto Md</b>  |                    |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 24 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                         |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM P-100. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

08051 101222

025203

NOV 25 1986

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 30469

REG. NO.

FOR  
1- STATE  
REGISTRAR

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>THELMA B. WALKER</b> |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/13/86</b>  |  | 2b. HOUR<br><b>12:45 PM</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>FEB 8, 1907</b>   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.                                   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>12 45</b>   |  | 8. IF UNDER 24 HRS<br>HOURS MIN.<br><b>12 45</b>   |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>                    |  | 9b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel County MD.</b>                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Crofton</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Crofton Convalescent Center</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Administrative Ass't/ Banking</b> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  | 13a. USUAL RESIDENCE (IF NOT IN HOSPITAL OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                |  | 13b. CITY OR TOWN<br><b>Pr. George's Hillcrest Hgts. MD</b>  |  |
| 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>20748</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward Boes</b>                        |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma Buck</b>   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                         |  |
| 17. SOCIAL SECURITY NO.<br><b>577-03-1359</b>                                       |  | 18. INFORMANT<br><b>Gail T. McGowan</b>   |  | 19. ADDRESS<br><b>1417 Knightsbridge Turn Crofton, Maryland 21114</b>                                    |  |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-Pulmonary Arrest</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>lung Tumor</b>   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Carcinoma of Breast</b>  |  |   |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Phleumonia Parkinson's disease**

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-6-1986</b> to <b>11-13-1986</b> that (I) (we) last saw the deceased alive on <b>11-13-1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>R. Arora</b>  |  |  |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>11/13/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RAKESH ARORA</b>   |  |  |  | 22e. ADDRESS<br><b>14300 GALLANT FOX LN #222 BOWIE, MD 20715</b>                     |  |   |  |

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>NOV 17, 1986</b>                            |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Resurrection Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Clinton, Pr. George's, Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Beall Funeral Home</b>     |  | ADDRESS<br><b>16000 Annapolis Road Bowie, MD 20715-3043</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 24 1986</b>                |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia D. ...</i>                                    |  |

MEDICAL CERTIFICATION

025203 000000

|              |                                |                  |   |                          |
|--------------|--------------------------------|------------------|---|--------------------------|
| Female       | Commissioner                   | USA              | X | Administrative Assistant |
| Pennsylvania | USA                            |                  |   |                          |
| Proctor      | Proctor on Convalescent Center |                  |   |                          |
| Working      | Mr. George's Hill at 1000      |                  |   |                          |
| Room         | Room                           |                  |   |                          |
| NO           | 517-03-1000                    | Call T. No. 0000 |   |                          |

XX

025203 000000

Room 1000, Mr. George's Hill at 1000  
Room 1000, Mr. George's Hill at 1000  
Room 1000, Mr. George's Hill at 1000



023478 NOV 12

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 0 4 7 0

REG. NO.

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Florence C Walton</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-5-86</b>                                |  | 2b. HOUR<br><b>3:15 a</b> M.   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3-30-10</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS                                     | IF UNDER 1 YEAR<br>MONTHS DAYS   | IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WASH. DC.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel</b> MD.                      |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Anne Arundel General</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Private Incl.</b>                              |  |
| 13a. STATE<br><b>MD.</b>  |  |   | 13b. COUNTY<br><b>Anne Arundel</b>   | 13c. CITY OR TOWN<br><b>Annapolis</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Michael J Driscoll</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Florence C Barbee</b>            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>578-05-8137</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Michael J Driscoll 670 AMERINDA, DEWE ANNAPOLIS, MD</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure + CVA</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Impending gangrene of both legs</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>2° to Cardio-iliac arterial occlusion disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Severe C.O.P.D.</b>   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-1-86</b> to <b>11-5-86</b> , that (I) <del>was</del> last saw the deceased alive on <b>11-4-86</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>will</del> (did not) view the body after death.  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>GARY M. RICHARDSON, MD</b>   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>11-5-86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GARY M. RICHARDSON, MD</b>  |  | 22e. ADDRESS<br><b>104 FORBES STREET ANNAPOLIS, MD 21401</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>11/10/86</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Olivet</b>  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Washington, DC</b>                  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>George P Kalos Funeral Home</b>  |  | ADDRESS<br><b>6160 OXON HILL RD OXON HILL MD</b>  | DATE REC'D. BY REGISTRAR<br><b>NOV - 7 1986</b>                                      | REGISTRAR'S SIGNATURE<br><b>Julia Swenson-Randall</b>                                  |  |

MEDICAL CERTIFICATION

6

47

53

35

021

1

9

9

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 30471

1- FOR  
STATE  
REGISTRAR

REG. NO.

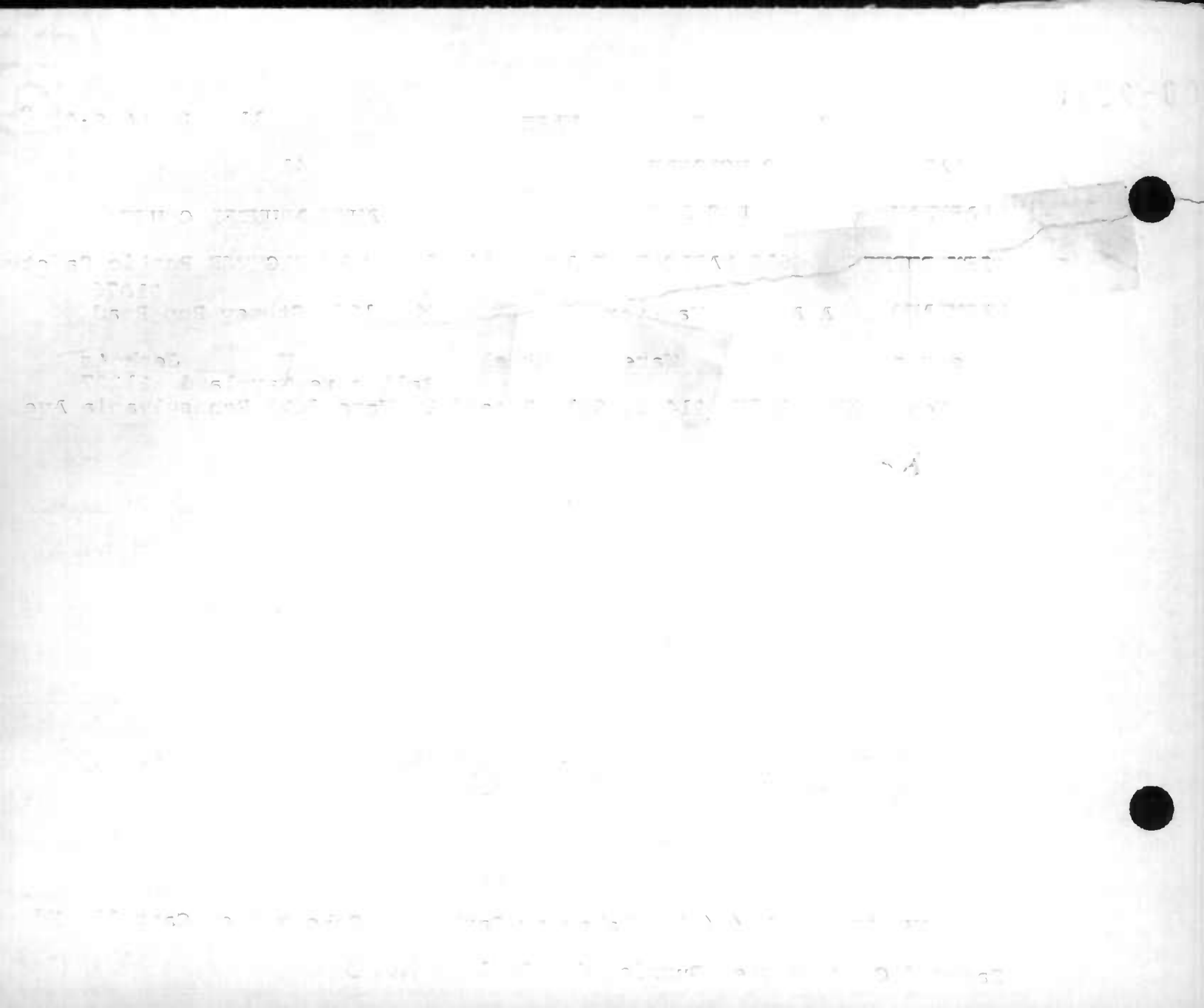
|  |   |   |   |   |   |
|--|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ROBERT E. WARE</b>   |   |   | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>2</b> YEAR <b>86</b>                        |   | 2b. HOUR<br><b>9:05</b> <sup>p</sup>  |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>CAUCASIAN</b>   | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>8</b> YEAR <b>45</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>41</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>                          |   |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>610 MARLBORO ROAD 21061</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>FIRE FIGHTER</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Public Safety</b>   |
| 13a. STATE<br><b>MARYLAND</b>  |   | 13b. COUNTY<br><b>A.A.</b>  | 13c. CITY OR TOWN<br><b>Hanover</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST <b>George</b> MIDDLE <b>E.</b> LAST <b>Ware</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Ethel</b> MIDDLE <b>W.</b> LAST <b>Jenkins</b>   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>1968 1971 214 50 6515</b>   |   | 17. INFORMANT <b>Baltimore, Maryland 21227</b><br><b>Ronald F. Ware 3022 Pennsylvania Ave.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b>   |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>5 min.</b>  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>hypercalcemia</b>   |   |   |   |   | <b>4 months</b>   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>malignant melanoma</b>  |   |   |   |   | <b>4 months</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>—</b>  |   |   |   |   |   |
| 19a. DATE OF OPERATION<br><b>—</b>   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>June</b> , 19 <b>86</b> , to <b>November</b> , 19 <b>86</b> , that (2) (we) lost<br>saw the deceased alive on <b>Oct 24</b> , 19 <b>86</b> , and that in (3) (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (4) (we) (did) (did not) view the body after death. |   |   |   |   |   |
| 22b. SIGNATURE<br><b>Laurence Austin Doyle M.D.</b>  |   |   |   | 22c. DATE SIGNED<br><b>11/3/86</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Laurence Austin Doyle M.D.</b>   |   |   |   | 22e. ADDRESS<br><b>Univ. of Maryland Cancer Center</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>   |   | 23b. DATE<br><b>11/5/86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lakeview Park</b>                                      |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Raymond C. Fink</b>   |   | ADDRESS<br><b>Glen Burnie, Md. 21061</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 3 1986</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |   |   |   | 25c. REGISTRAR'S NAME<br><b>[Name]</b>  |   |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy and return it to the funeral director. Page 4 may be returned by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return pages 1 and 2 to the State Department of Health and Mental Hygiene prior to burial, cremation or other disposition of the body. If the medical examiner has been notified of the death, the medical examiner must be notified of the burial, cremation or other disposition of the body. IMPORTANT: If item 21 is marked or item 18 is checked, the medical examiner must be notified of the burial, cremation or other disposition of the body.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  | REG. NO. 8630472                           |  |                              |   |          |   |  |
|---|--|--|--|--|--|--|------------------------------|---|----------|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR           |  |                              |   | 2b. HOUR |   |  |
| DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST   |  |  |  |  | 11 6 86                                    |  |                              |   | 615 A M  |   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.   |                              | IF UNDER 1 YEAR MONTHS DAYS   |          | IF UNDER 24 HRS. HOURS MIN.   |  |
| Male  |  | White  |  | 4 9 17   |  | 69   |                              |   |          |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                              |   |          |   |  |
| Washington DC   |  | USA  |  |  |  | Anne Arundel MD  |                              |   |          |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |                              | 12b. KIND OF BUSINESS OR INDUSTRY   |          |   |  |
| Annapolis   |  | Anne Arundel General Hospital  |  |  |  | Retired  |                              | Plumber   |          |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                              | 13e. STREET ADDRESS / ZIP CODE  |          |   |  |
| MD  |  | AA   |  | Edgewater  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |                              | 1634 Bay Ridge Road 21037   |          |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST |  |                              |   |          |   |  |
| John Webster  |  |  |  |  | Lola Keys                                  |  |                              |   |          |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES)   |  |  |  |  | 16b. SOCIAL SECURITY NO.                   |  | 17. INFORMANT ADDRESS        |   |          |   |  |
| Yes WWII  |  |  |  |  | 578-03-2937                                |  | Ruby R. Webster- same as #13 |   |          |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |                              |   |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| IMMEDIATE CAUSE (a) Cardiorespiratory arrest  |  |  |  |  |  |  |                              |   |          | 5 minutes   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Cor pulmonale  |  |  |  |  |  |  |                              |   |          | 2 years   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) COPD   |  |  |  |  |  |  |                              |   |          | 20 years  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |  |  |  |  |                              |   |          |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |                              | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |  |                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |          |   |  |
|   |  |  |  | P.M. 19  |  |  |                              |   |          |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |                              | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |          |   |  |
|   |  |  |  |  |  |  |                              |   |          |   |  |
| 22a. I certify that (a) this hospital attended the deceased from 10/28, 1986, to 11/6, 1986, that (b) I saw the deceased alive on 11/5, 1986, and that in my opinion death occurred on the date and hour and from the causes stated above. (c) I did not view the body after death. |  |  |  |  |  |  |                              |   |          |   |  |
| 22b. SIGNATURE DEGREE   |  |  |  |  |  | 22c. DATE SIGNED   |                              |   |          |   |  |
| Gregory S. Neiley MD  |  |  |  |  |  | 11/6/86  |                              |   |          |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  |  | 22e. ADDRESS   |                              |   |          |   |  |
| Gregory S. Neiley MD  |  |  |  |  |  | 134 Owensville Rd West River MD 21088  |                              |   |          |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                              | 23d. LOCATION CITY OR TOWN COUNTY STATE   |          |   |  |
| Burial  |  |  |  | Nov. 10, 1986  |  | Maryland Veterans  |                              | Crownsville AA MD   |          |   |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |  |  |  | 24e. ADDRESS   |                              | 25a. DATE REC'D. BY REGISTRAR   |          | 25b. REGISTRAR'S SIGNATURE  |  |
| Taylor Funeral Chapel-Annapolis MD  |  |  |  |  |  |  |                              | NOV 14 1986   |          | Julia Davidson-Randall  |  |

BP



024378 NOV 19 86

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |                           |  |  |
|---|--|---|--|---|---------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>FRANCIS X WELCH</i>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>11-16-86</i> |   | 2b. HOUR<br><i>1210 M</i> |  |  |
| 3. SEX<br><i>MALE</i>   |  | 4. RACE<br><i>WHITE</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>10-24-04</i>   |                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>82</i> YRS<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Washington DC</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>ANNE ARUNDEL</i> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><i>ANNAPOLIS</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>ANNE ARUNDEL GENERAL HOSPITAL</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>ATTORNEY</i>   |                           | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Uti Public Report</i>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><i>MD</i>   |  |   |  | 13b. COUNTY<br><i>A.A.</i>  |                           | 13c. CITY OR TOWN<br><i>CHURCHTON</i>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Richard M. Welch</i>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Mary Agnes Owens</i>  |                           |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>577033606</i>  |  | 17. INFORMANT<br>ADDRESS<br><i>Audrey M. Welch Same as #13</i>  |                           |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>CVA</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>metastatic Carcinoma of the prostate</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ |  |   |  |   |                           |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |   |  |   |                           |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |                           |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                           |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, that (we) (did) (did not) view the body after death.    |  |   |  |   |                           |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |                           | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS  |                           |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>11-18-86</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Our Lady of Sorrows</i>  |                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Owensville A.A. Co. Md.</i>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Hardesty Funeral Home Annapolis Md.</i>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 18 1986</i>   |                           | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2, and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. (Page 4 may be retained by the funeral director.)

IMPORTANT: If item 21 is marked as having been only injury, or other traumatic event, a medical examiner must be notified of this.

BP \_\_\_\_\_



| TO: (Name and address of agency or individual to whom the report is made) |  |
|---|--|
| FROM: (Name and address of agency or individual making the report)        |  |
| SUBJECT: (Brief description of the subject of the report)                 |  |
| DATE: (Date of report)  |  |
| CLASSIFICATION: (Classification of report)                                |  |
| AUTHORITY: (Authority for report)   |  |
| FUNDING: (Funding source)   |  |
| ABSTRACT: (Summary of report)   |  |
| REFERENCES: (References to other reports)                                 |  |
| COMMENTS: (Comments on report)  |  |
| REMARKS: (Remarks on report)  |  |
| CONCLUSIONS: (Conclusions of report)                                      |  |
| RECOMMENDATIONS: (Recommendations of report)                              |  |
| ACTION: (Action to be taken)  |  |
| APPROVAL: (Approval of report)  |  |
| SIGNATURE: (Signature of official)  |  |
| TITLE: (Title of report)  |  |
| AUTHOR: (Author of report)  |  |
| EDITOR: (Editor of report)  |  |
| REVIEWER: (Reviewer of report)  |  |
| DISTRIBUTION: (Distribution of report)                                    |  |
| STORAGE: (Storage of report)  |  |
| RETRIEVAL: (Retrieval of report)  |  |
| ARCHIVAL: (Archival of report)  |  |
| DISSEMINATION: (Dissemination of report)                                  |  |
| PUBLICATION: (Publication of report)                                      |  |
| OTHER: (Other information)  |  |



025854 DEC 13 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

3 0 4 7 4

REG. NO.

|   |  |   |   |   |  |   |  |  |  |
|---|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>William M. West</i>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>11-22-86</i>              |   |  | 2b. HOUR<br>M<br><i>8 AM</i>  |  |  |  |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>Caucasian</i>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>3 - 23 - 1896</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><i>90</i>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>United States</i>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>ANNE ARUNDEL CO</i> MD.                              |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Annapolis</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Anne Arundel General Hosp</i> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Chem. Engineer</i>       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Crown Cork/Seal</i>  |  |
| 13a. STATE<br><i>Maryland</i>   |  | 13b. COUNTY<br><i>Anne Arundel</i>  |   | 13c. CITY OR TOWN<br><i>Severna Park</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><i>637 Ravine Rd./21146</i>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>William C. West</i>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Kate Schwartz</i>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>Yes</i>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>WW I</i>  |   | 17. INFORMANT<br>ADDRESS<br><i>Betty Herrmann 4 Westerly Way, Severna Park, MD, 21146</i>   |  |   |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>OLD AGE - DIED IN HIS SLEEP</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |   |   |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19          |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART I OR PART 2)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE FARM, ETC.) |   | 21i. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11-22</i> , 19 <i>86</i> , to <i>11-22</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>none</i> , 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>John P. Jackson</i>  |  |   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br><i>11-22-86</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>John Jackson</i>  |  |   |   |   | 22e. ADDRESS<br><i>1833 WEST DR, ANNAPOLIS, MD</i>   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  |   | 23b. DATE<br><i>11 - 25-86</i>                                      |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Parkwood Cemetery</i>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Parkville, Balto., Md</i> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Barranco Funeral Home</i>  |  |   |   |   | 495 Ritchie Hwy. 21146<br><i>Severna Park, MD</i>  |   | 25. DATE REC'D. BY REGISTRAR<br><i>NOV 28 1986</i>                         |  |  |
|   |  |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |   |  |  |  |

BP



024264 NOV

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1E, ONE SPACE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THIS PAGE. PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M
 BP  
 DHMH - 17  
 (VR A15 ME (5))

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

 1- FOR  
 STATE  
 REGISTRAR

|  |  |  |  |  |  |  |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |
|--|--|--|--|--|--|--|--|-------------------------|--|------------------|--|--------------------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE KNOWN OF DEATH |  |                  |  | MONTH                    |  | DAY   |  | YEAR |  | 2b. HOUR |  |
| Michael  |  | S.   |  | Westberg   |  | 11   |  |                         |  | 11               |  | 19                       |  | 86    |  | M    |  |          |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YR.          |  | IF UNDER 24 HRS. |  | 7c. DATE PRONOUNCED DEAD |  | MONTH |  | DAY  |  | YEAR     |  |
| male   |  | white  |  | 5-25-1948  |  | 38 YRS.  |  |                         |  |                  |  | 11                       |  | 11    |  | 19   |  | 86       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |
| Georgia  |  | U.S.A.   |  |  |  | Anne Arundel County, MD  |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |
| Davidsonville  |  | #69 Brick Church Rd. (street)  |  | Lawyer   |  | law  |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS     |  |                  |  |                          |  |       |  |      |  |          |  |
| Md.  |  | A.A. Co.   |  | Davidsonville  |  |  |  | 714 Intrepid Way 21035  |  |                  |  |                          |  |       |  |      |  |          |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |
| John   |  | W.   |  | Westberg   |  | Sybil  |  | Harris                  |  |                  |  |                          |  |       |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS  |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |
| yes  |  | 1967-1968  |  | 217-48-6816  |  | Barbara Westberg same as 13  |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | PART I DEATH WAS CAUSED BY:  |  |  |  |  |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |
|  |  | IMMEDIATE CAUSE (a) <u>Gunshot wound of head</u>   |  |  |  |  |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |
|  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |
|  |  | Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:  |  |  |  |  |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |
|  |  | (b) _____  |  |  |  |  |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |
|  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |
|  |  | (c) _____  |  |  |  |  |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).            |  |  |  |  |  |  |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |  |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |
|  |  |  |  |  |  |  |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |
| 20. AUTOPSY?   |  |  |  |  |  |  |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |
| HEAD ONLY <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                 |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |  |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |
|  |  | 6 P.M. 11 11 19 86   |  | self inflicted   |  |  |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION  |  |  |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |
|  |  | street   |  | #69 Brick Church Rd, Davidsonville, A.A., MD   |  |  |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an  |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion   |  |  |  |  |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |
| death resulted from:   |  | Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |
| ACTUAL SIGNATURE   |  | TITLE (SPECIFY)  |  |  |  |  |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  | ADDRESS  |  |  |  |  |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |
| William M. Zane, M.D.  |  | 111 Penn St. Balto.MD.   |  |  |  |  |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |
| Burial   |  | 11/15/86   |  | All Hallows Cem  |  | Birdsville, A.A., MD.  |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |
| 24. FUNERAL DIRECTOR NAME  |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |
| HARDESTY FUNERAL HOME  |  | 12 RIDGELY AVE. ANN. MD, 21401   |  | NOV 14 1986  |  | Julia Davidson-Rodgers   |  |                         |  |                  |  |                          |  |       |  |      |  |          |  |

2001 100 100 100 100

2001 100 100 100 100

2001 100 100 100 100

025153 NOV 25

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |              |  |   |  |  |  |  |  | REG. NO. 30416  |  |
|--|--|--------------|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST: Debra MIDDLE: L. LAST: WHITE  |  |              |  |   |  | 2a. DATE KNOWN OF DEATH<br>MONTH: 11 DAY: 1 YEAR: 1986       |  | 2b. HOUR<br>M: 02  |  |   |  |
| 3. SEX: FEMALE   |  | 4. RACE: CAU |  | 5. DATE OF BIRTH<br>MONTH: 10 DAY: 9 YEAR: 62   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY: 24 YRS.                  |  | 7. IF UNDER 24 HRS.<br>MONTHS: DAYS: HOURS: MIN:   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  |              |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Annapolis   |  |              |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Anne Arundel Gen. |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK)<br>COMPUTER OPERATOR  |  |   |  |
| 13a. STATE<br>MD   |  |              |  | 13b. COUNTY<br>AA   |  | 13c. CITY OR TOWN<br>Annapolis                               |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 14. FATHER'S NAME<br>ROBERT E. DAVIS   |  |              |  | 15. MOTHER'S MAIDEN NAME<br>MARGARET WAGNER   |  |  |  | 16. ADDRESS<br>993 MT. HOLLY DRIVE   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>NO   |  |              |  | 16b. SOCIAL SECURITY NO.<br>218-82-1256   |  | 17. INFORMANT<br>ROBERT DAVIS ANNAPOLIS, Md. 21401           |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>8189 IMMEDIATE CAUSE (a) Multiple Trauma.<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. }<br>(b) Motor Vehicle Acc.<br>(c) }<br>DUE TO, OR AS A CONSEQUENCE OF  |  |              |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I   |  |              |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>1 AM 1 Nov 1986  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br>Ejected From Auto.  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>Street   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>RTE 2 Severna Park AA Md.   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |              |  |   |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE<br>William P. Jones, MD   |  |              |  | TITLE (SPECIFY)<br>M.D. Deputy  |  |  |  | DATE SIGNED<br>1 Nov 86  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>William P. Jones, M.D.  |  |              |  | ADDRESS<br>695 America Crt. Davidsonville, Md 21035   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |              |  | 23b. DATE<br>11-5-86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>OUR LADY OF THE FIELDS |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>MILLERSVILLE A.A. Md. |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>ROBERT E. EVANS  |  |              |  |   |  | ADDRESS<br>1212 WEST STREET ANNAPOLIS                        |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 25 1986   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Henderson-Randall               |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. HAVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESIDENT STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESIDENT ST., BALTIMORE, MD. 21201

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))





024311 NOV 18 1986

18a, 21a, 21b, 21c, 21d, 21e, 21f, 22a, G-622

REGISTRAR M.E., 12/11/86

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 0477

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
RICHARD ALLEN WILLIAMS, JR.

2a. DATE KNOWN OF DEATH ☒ ESTIMATED ☐ MONTH DAY YEAR 11-10-86 2b. HOUR M 11:20A

3. SEX Male 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR Aug. 22, 1964 22 YRS. 6. AGE (IN YEARS LAST BIRTHDAY) 22 7. C. DATE PRONOUNCED DEAD 11-10-86 2d. HOUR 11:20A

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.

10. CITY OR TOWN OF DEATH Glen Burnie 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter 12b. KIND OF BUSINESS OR INDUSTRY Construction

13a. STATE MD 13b. COUNTY A.A. 13c. CITY OR TOWN Glen Burnie 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET ADDRESS 165 St. James Drive 21061

14. FATHER'S NAME FIRST MIDDLE LAST Richard A. Williams 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Sears

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS Same as Barbara Grierson - H13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Multiple Drug Intoxication  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last  
(b) DUE TO, OR AS A CONSEQUENCE OF  
(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR Primary CONTRIBUTING ☐ CAUSE OF DEATH ? P.M. 11 9 1986 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject injected drugs

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) unknown 21f. LOCATION STREET CITY OR TOWN COUNTY STATE unknown Anne Arundel, Md.

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒.

ACTUAL SIGNATURE Gregory R. Kauffman, M.D. TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 11-11-86

EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE Nov. 14, 1986 23c. NAME OF CEMETERY OR CREMATORY Hillcrest 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. MD

24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel Annapolis MD ADDRESS 25a. DATE REC'D. BY REGISTRAR NOV 14 1986 25b. REGISTRAR'S SIGNATURE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BR 373  
DHMH - 17  
(VR A15 ME (5))

12345678910

UNITED STATES

NOV 10 1962

Handwritten mark resembling a stylized 'K' or 'X'.

024649 NOV 20 1986

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 3 0 4 7 8

REG. NO.

EST

|  |  |   |  |   |  |  |   |  |  |
|--|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>THELMA L WILSON   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>NOVEMBER 12, 1986                  |   |  | 2b. HOUR<br>1.34 AM  |   |  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>DEC. 2, 1911  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.                                     |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>UNITED STATES   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ANNE ARUNDEL COUNTY MD.                |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>GLEN BURNIE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NORTH ARUNDEL HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SEAMSTRESS |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>LeBon Bros. Co  |  |
| 13a. STATE<br>MARYLAND   |  |   | 13b. COUNTY<br>ANNE ARUNDEL  |   | 13c. CITY OR TOWN<br>PASADENA  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HOWARD M. ZIEGLER  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>CORA MILLER           |   |  | 13e. STREET ADDRESS / ZIP CODE<br>8847 HIGHPOINT RD. 21122                     |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>—           |   | 17. INFORMANT<br>ADDRESS<br>PO Box 571<br>PASADENA, MD 21122   |  | 17. INFORMANT<br>JAMES E. WILSON  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple Myeloma<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) metastases<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.  |  |   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                    |  |   |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br>H. T. Towhidan   |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HAMED TOWHIDAN, M.D.  |  |   |  |   | 22c. ADDRESS<br>3236 MOUNTAIN ROAD<br>PASADENA, MARYLAND. 21122  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |   | 23b. DATE<br>Nov. 15, 1986   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>LOUDON PARK CEMETERY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE BALTIMORE MD                            |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mc Cully F.H. OF PASADENA  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 18 1986   |  | 25b. REGISTRAR'S SIGNATURE<br>J. A. Gordon  |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified.

RECEIVED  
100000  
100000

100000  
100000

100000  
100000

100000  
100000

100000  
100000

100000  
100000

100000  
100000

100000  
100000

100000  
100000

100000  
100000

100000  
100000



023707 NOV 13 1986

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8630479

|  |  |   |   |   |   |   |                                  |  |   |  |
|--|--|---|---|---|---|---|----------------------------------|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Charles Horner Younkin  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 7, 1986 |   |   | 2b. HOUR<br>9:15 P.M.   |                                  |  |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>September 19, 1893  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>93 YRS.                                  |                                  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Pennsylvania  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel Co. MD.                |                                  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Brooklyn Park   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Meridan Nursing Center |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Auditor |                                  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Civil Service   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |   |   |   | 13b. COUNTY<br>Prince George                                      |   | 13c. CITY OR TOWN<br>Hyattsville |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Elias Polk Younkin   |  |   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Emma Jane Horner |   |                                  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWI  |   | 17. INFORMANT (Daughter)<br>Mrs. Charlotte Anderson   |   | ADDRESS<br>8 S. Meadow Dr. Glen Burnie, Md. 21061                           |                                  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>hypertension, osteoarthritis, senile dementia</u> |  |   |   |   |   |   |                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |   |   |                                  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |                                  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |   |   |                                  |  |   |  |
| 22b. SIGNATURE<br>Marcia Kane MD   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |   |   |                                  | 22c. DATE SIGNED<br>11/8/86  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Marcia Kane, MD   |  |   |   | 22e. ADDRESS<br>Hamonds Lane, Brooklyn Park, Md.  |   |   |                                  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>Nov 12, 1986   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Union Cemetery  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Myersdale Somerset PA.        |                                  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Singleton Funeral Home   |  |   |   | Glen Burnie, Maryland<br>ADDRESS<br>1 Second Ave. SW  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 10 1986                                |                                  | 25b. REGISTRAR'S SIGNATURE<br>Julia Anderson-Rendall   |   |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

